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DEVELOPMENT AND IMPLEMENTATION

OF A COMPREHENSIVE RISK MANAGEMENT PROGRAM

AT THE USAF ACADEMY HOSPITAL

A Problem Solving Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

By

Captain Charles W. Boone, USAF, MSC

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This study was conducted to develope and implement a comprehensive risk management program at a U.S. Air Force Hospital. It was conducted due to a sharp increase in the incidence of malpractice in both military and civilian sectors, and due to the amount of curre malpractice claims being filed yearly. The author explained the current problems, developed a comprehensive risk management program, and made recommendation on its implementation.

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I. INTRODUCTION

Development of the Problem

The incidence of malpractice in medicine (and resultant liability on the part of hospitals) has reached enormous proportions in both the military and civilian sectors. In the civilian sector, some experts have estimated that the cost of malpractice insurance alone accounts for as much as five percent of the total cost of caring for a patient.

In 1961, Herman and Ann Somers wrote that the vast increase in malpractice claims and suits resulted from a symptom of deteriorating doctor/patient relationships that had been spreading ominously. Until 1974, the rise in malpractice insurance premiums was reasonably con-sistent with the rise in national health care expenditures and increases in annual malpractice claims and payments. During this period, the rate of increase was about 10-12 percent per year.[1]

Estimates of total premiums paid by all health care providers differ widely but are generally believed to have been around $1 billion in 1975.[2] Premium rates for hospitals differ greatly. They are usually experience-related. Estimates of total premiums paid by private hospi-tals in 1975 was $700 million.[3] In 1976, estimates of premiums paid by hospitals, alone, exceeded $1 billion.[4] This represents a 1,000 percent increase in annual hospital premiums paid between 1972 and 1976.[5]

In 1975, the Department of Health, Education, and Welfare estimated that there were about two million medical injuries annually of which some 700,000 appeared to involve some form of medically negligent conduct.[6]

Similarly, the number of malpractice claims brought against the

government as a result of medical procedures performed in military hospitals has risen significantly during the past ten years. In 1963, only three (3) claims of medical malpractice were filed against the Air Force. That same year, a total of $12(!) was paid by the Air Force in malpractice claims.[7]

During the six-year period 1963-1968, a total of 26 claims had been filed against the Air Force (4.3 per year).[8] However, during the next six-year period, 1969-1974, 374 claims (62.3 per year) were filed.[9] During the three-year period 1977-1979, 772 malpractice claims (284 per year) were filed.[10] In Fiscal Year 1979, alone, 302 new malpractice claims were filed, totaling $372 million.[11]

Figure 1 demonstrates the increase in numbers of claims and in dollar amounts claimed against the Air Force for malpractice in its hospitals over the last ten years.

NUMBER OF NEW CLAIMS SUBMITTED	$ AMOUNT CLAIMED ($ MILLIONS)
FY 1970 - 41	19
FY 1975 - 151	60
FY 1977 - 210	122
FY 1978 - 260	298
FY 1979 - 302	372

Figure 1. Increase in Air Force Malpractice Claims, FYs 1970-1979. Source: Air Force Times, March 3, 1980, p. 3.

The United States Air Force Academy Hospital has been named in an increasing number of claims for increasing amounts of dollars. During Fiscal Years 1978 and 1979, the Hospital has been named in eight malpractice claims, for an amount exceeding $12 million, making it the most often named hospital in the Air Force with under one hundred beds, for malpractice claims.

Because of the large number of malpractice claims against the government naming Air Force Hospitals (and the potential cost to the government resulting from such claims), the Air Force determined that its hospitals should develop risk management (RM) programs.

The pressure to develop a risk management program at the U. S. Air Force Academy Hospital was multi-fold:

(1) Program development was directed by Headquarters United States Air Force;[12]

(2) High cost to the government to either defend against claims in court or to settle out of court;

(3) High visibility of the Hospital because of its location at the Air Force Academy;

(4) High visibility of patients at the Hospital (cadets are very often appointed to the Academy by members of Congress, and cadets and their parents are not hesitant to contact Congressmen); and

(5) High visibility of being named for malpractice more often than any other Air Force hospital of comparable size.

Because of these pressures, and in an effort to improve quality of patient care delivered by the Hospital, top management wanted to develop a comprehensive risk management program at the Hospital. It was expected than an effective risk management program would:

(1) Meet Headquarters United States Air Force requirements;

(2) Decrease both the number of claims filed and the dollar amounts claimed against the government as a result of medical treatment provided at the U. S. Air Force Academy Hospital;

(3) Improve the quality of care delivered by the Hospital; and simultaneously,

(4) Improve the Hospital's reputation for providing quality medical treatment, which is extremely important to Hospital management, given the Hospital's high degree of visibility.

Statement of the Problem

The problem was to develop and implement a comprehensive risk management program at the U. S. Air Force Academy Hospital.

Objectives of the Research Project

Objectives of the research project were:

(1) To describe the need for a comprehensive risk management program;

(2) To collect, analyze and evaluate information from available literature, personal interviews and seminars or workshops attended so that such information could be effectively utilized in developing and implementing a comprehensive risk management program at the U. S. Air Force Academy Hospital;

(3) To develop alternative proposals which could be utilized in a comprehensive risk management program at the U. S. Air Force Academy Hospital;

(4) To evaluate alternative proposals which could be utilized in a comprehensive risk management program at the U. S. Air Force Academy Hospital;.

(5) To arrive at the optimal feasible solution (i.e., the best risk management program) to implement at the U. S. Air Force Academy Hospital;

(6) To develop a comprehensive risk management program at the U. S. Air Force Academy Hospital based upon the optimal feasible

solution; and

(7) To implement a comprehensive risk management program at the U. S. Air Force Academy Hospital.

Criteria

Criteria for the program were:

(1) Implementation of the program must be within the authority of the Commander, U. S. Air Force Academy Hospital.

(2) In conjunction with criterion number 1, the program must not conflict with existing Department of Defense or U. S. Air Force regulations or policies.

(3) The program must meet the needs of the U. S. Air Force Academy Hospital.

(4) The program must be acceptable to U. S. Air Force Academy Hospital management and providers.

(5) Cost of implementation of the program must not exceed expected benefit to be derived from the program's implementation.

Limitations

The following limitations impacted upon the program to be implemented:

(1) Implementation of the program must be made within existing budgetary restraints (i.e., no additional money will be allocated for implementation of this program).

(2) The program must be implemented with no increase in existing hospital staff (i.e., no additional manpower will be allocated to administer the program).

(3) The program must be implemented no later than 25 April 1980.

Definitions

See Appendix A.

Literature Review

A thorough review of health care literature indicates that civilian hospitals have experienced the same malpractice problems and, perhaps, to a greater magnitude, than have military hospitals. Beyond the problem of being sued, itself, civilian hospitals have had the related problem, in nearly every state, of obtaining malpractice insurance. As a result, many hospitals in America have utilized a good deal of resourcefulness in coping with these problems. Additionally, state legislatures have reacted to the malpractice problem in various ways. Further, the American Hospital Association and the State Hospital Associations have attempted to ameliorate the problem. The requirement for risk management programs to be developed in hospitals is one means by which hospitals, hospital associations, and legislatures have tried to decrease the likelihood and severity of malpractice suits. The following is a discussion of (1) the problem in the civilian sector, and (2) how the civilian sector has handled the problem.

During the last ten years, increasing public and consumer awareness has precipitated an escalation of malpractice suits, based on negligence, against hospitals and physicians. In the Risk Management Primer, Paul Kessler attributes escalation in malpractice suits to six factors:

(1) Diagnostic and treatment procedures have become complex and sophisticated.

(2) Medical care delivery has become more impersonal.

(3) Patient attitudes have changed.

(4) The cost of medical care has skyrocketed.

(5) The size of professional and general liability settlements has

grown out of proportion, and

(6) The professional and general responsibility of physicians and hospitals has broadened.[13]

The cost of research in preparing and trying malpractice suits has also escalated, primarily because of the complexity of liability cases. The caseload has increased and more time is being allotted to each case. Additionally, cash settlements have been frequent and astonishingly high. To meet these rising costs, many insurance companies have turned to physicians and hospitals and, in some cases, have levied premium increases of over 200 percent.[14] Additionally, many major insurance companies have discontinued malpractice coverage. As a result, by 1975, only twelve insurance companies offered malpractice coverage. These companies offered to write malpractice insurance but at much higher rates using the threat of withdrawal of all coverage to secure rate increases in states they covered.[15]

Herman M. Somers states that the year 1975 was a landmark of sorts. In that year, America was treated to its first exhibition of doctor strikes, most conspicuously in California and New York where doctors withheld their services except for emergency cases, and hospitals proceeded to close their doors or to contract out services. In some states, physicians threatened more serious actions.[16] These uncommon actions were mainly triggered by disputes over malpractice insurance, extraordinary increases in premium rates demanded by insurance carriers, and in some cases, real or threatened withdrawal of carriers from the malpractice business, which created the possibility of no available coverage. The malpractice problem, according to Somers, had been growing for a long time, but had been largely neglected until it reached critical proportions

in 1975.[17]

The high cost of malpractice coverage was seen by hospitals as unjustifiable. Hospitals pay for the coverage of regular staff physicians as do other institutions (like health maintenance organizations). Increasingly, however, hospitals also pay for sharing the costs for attending physicians. Hospital premiums seemed to be rising more rapidly than the premiums for individual physicians. Further, hospitals complained that, for the most part, the increases had no relation to actual malpractice experience.[18]

In New York State, where Argonaut Insurance Company was carrying most of the malpractice insurance, a doctor rebellion was triggered when the company requested a 197 percent increase in premiums in 1975 which it said they needed in order to break even. (The same company had asked for a 274 percent increase in California that same year.)[19]

Many other states found the apparent lack of relationship between the premium increases and actual claims-experience to be a mystery apparently intelligible only to the insurers.[20] For example, in New Mexico, doctors had paid Travellers Insurance Company more than $3,600,000 in liability insurance premiums from 1971 to 1974. During that same period, Travellers had paid out only $70,000 in claims. However, in 1975, the company asked for a 74 percent increase.[21]

For one year in which Argonaut had projected a loss of $2,503,000, upon consulting actuaries using the same data, New Jersey Hospital Association came up with earnings of $1,525,000: a difference of over $4,000,000. As a result, Argonaut had consistently overestimated its claim reserves 2.68 times greater than necessary.[22]

In 1975, the American Bar Association (ABA) Commission on Medical

Professional Liability said that one of the long-term benefits of the malpractice crisis was that the unavailability of commercial liability insurance caused physicians and hospitals to self-insure, thus forcing them to begin to analyze the nature of the malpractice problem.[23]

The number of malpractice claims increased by approximately 20 percent annually from 1970-1976. In 1974, the year before the malpractice crisis resulted in a physician strike in California, one of every ten physicians insured by the St. Paul Fire and Marine Insurance Company was sued for professional negligence.[24]

Michigan State Medical Society reported 285 claims resulting in payment of $6 million from March through November 1977.[25]

In 1970, 6.5 percent of all physicians were sued. The National Association of Insurance Commissioners (NAIC) reported 14,074 closed (settled) claims against physicians between July 1, 1975 and June 30, 1976.[26] The department of Health, Education and Welfare's Commission on Medical Malpractice estimated that 12,000 medical malpractice claims were filed in 1970 which resulted in $80.3 million paid in compensation.[27] Fifer states that despite the volume and expense of suits and judgments, the above figure may represent only the tip of the liability iceberg.[28]

In order for hospitals to manage risk, it seems beneficial to know when and where malpractice is most likely to occur. Schwartz and Komesar quote 1972 data showing a large number of severe injuries resulting from malpractice of which only one in every fifteen led to malpractice claims.[29] The NAIC closed-claim study revealed that 85 percent of all loss dollars paid by insurance companies are for claims originating in the hospital setting and that 81 percent of payments relate to surgery, including post-surgical care.[30]

In 1975, the ABA Commisssion on Medical Professional Liability concluded that of all indemnity dollars paid by insurance companies, 84 percent were for hospital related claims, and 82 percent were related to surgery and surgical care.[31]

A Michigan study reported the hospital as the site of 70 percent of claims, and a 1970 multi-state Westat study reports that 95 percent of hospital claims were against short-term general hospitals and 75 percent against not-for-profit institutions.[32]

Ohio data suggested that hospitals with fewer than 500 beds sustain more claims and losses than hospitals with more than 500 beds.[33]

The Michigan State Medical Society stated that 51 percent of the defendants in malpractice actions were Board Certified; 57 percent were age 35 to 50 years; and the specialists most frequently sued were as follows:

General Surgeons - 20.7 percent

Obstetricians/Gynecologists - 21.8 percent

General Practitioners - 12.3 percent

Orthopedists - 7.7 percent

Internists - 4.6 percent [34]

Data from Los Angeles showed a concentration of litigation among a minority of practitioners. Forty-six of the 8,000 physicians in Los Angeles accounted for ten percent of all claims and 30 percent of all payments during a four-year period in the 1970s.[35] The NAIC study reported that 2,961 of 4,248 paid claims (or 70 percent) were against surgeons, especially orthopedists, obstetricians, gynecologists, plastic surgeons, head and neck surgeons, cardiovascular surgeons, and neuro-surgeons.[36]

According to the California Medical Insurance Feasibility Study
(CMIFS), the two most frequent sites of incidents that result in claims
against the hospital or physician are the operating room (71.8 percent)
and the patient's room (12 percent). However, the Ohio study concluded
that the patient's room was the most likely source for a claim (39 per-
cent) and the emergency room was the second most likely (16.3 percent).[37]

Fifer states that most malpractice claims result from (1) a poor
relationship between the physician and the patient, (2) a poor treat-
ment outcome, or (3) an excessively high bill.[38]

Analysis of malpractice claims in 1970 by the Department of Health,
Education, and Welfare's Commission on Medical Malpractice concluded
that 86 percent alleged improper treatment while only 14 percent alleged
improper diagnosis.[39] More recent data from the St. Paul survey (1973 to
1978) indicate that of 19,417 claims, 25 percent claimed improper diag-
nosis (especially relating to counseling, fractures, and dislocations).
These data seem to indicate a shift away from sins of commission toward
sins of omission.[40] Fifer states that it is the medically related cases
such as nerve injuries and cardiac arrests that cause permanent disabi-
lity and death and, which contribute most heavily to liability costs.[41]

The Malpractice and Accident Prevention Program initiated by the
Ohio Joint Underwriting Authority in 1975, analyzed claims from 150
hospitals in terms of their causes. The groups findings, displayed
by frequency of occurrence, revealed:

(1) 11 percent of claims were due to negligence in the operating
room, including the administration of anesthesia;

(2) 10.1 percent to improper diagnosis;

(3) 9.2 percent to medical errors;

(4) 9.2 percent to lack of staff attention;

(5) 9.2 percent to falls from hospital beds and tables;

(6) 6.9 percent to accidents on the way to treatment;

(7) 4.3 percent to burns of all types;

(8) 4.1 percent to infections;

(9) 3.1 percent to loss of personal property;

(10) 32.1 percent to all other causes combined.[42]

In another recent article, King, et al, reported that the following were the most frequent reasons for claims:

(1) Death and/or brain damage caused by anesthesia administered for all types of surgery.

(2) Deaths caused by failure to diagnose cancer.

(3) Deaths resulting from failure to diagnose and adequately treat underlying pathologic coronary conditions.

(4) Reactions to diagnostic procedures and diets, e.g., aortagrams, intravenous pyelograms.

(5) Postoperative infections.

(6) Laparoscopies.

(7) All procedures related to obstetrics and gynecology.[43]

Probably the most detailed data on hospital-based medically related patient injuries were presented by the California Medical Insurance Feasibility Study. The purpose of this study was to determine the type, frequency and severity of medically related patient disabilities without regard to liability. The study defined medically caused patient disabilities as potentially compensable events (PCE) and established threshold levels for such events.[44] Using generic screening criteria, researchers reviewed medical records from twenty-three

California hospitals. The review resulted in the discovery of 570 PCEs in the 20,864 records reviewed, an incidence of 4.65 percent.[45]

The study determined the severity of injury and found that 86.5 percent of the injuries were temporary or resulted in minor permanent damage to patients, and 9.7 percent resulted in death. The study concluded that 17 percent of injuries would likely result in liability to the hospital and/or a physician. As a result of this study, it was projected that California hospitals would be responsible for 14,000 PCEs leading to 23,800 valid claims and 13,600 deaths, suggesting that medically related patient injury is a profound problem indeed.[46]

Numbers and Dollar Amounts of Claims

The number of medical malpractice claims is estimated at 20,000 annually.[47] In 1977, of 5 percent of all incidents which resulted in payment of a claim, less than $10,000 was paid. In about 50 percent of the cases, less than $2,000 was paid. Only 3 percent exceeded $100,000. Less than one-tenth of one percent of claims paid were for one million dollars or more. In 1977, only seven claims paid were for one million dollars or more.[48]

In 1974, 43 percent of the claims paid were for less than $5,000. Over 56 percent received less than $10,000. Only one percent of all awards exceeded $500,000. The over $500,000 awards, however, represented about 23 percent of money paid out.[49]

Dealing With the Problem

Two devices have been most commonly employed to make sure that insurance is available. More frequently used is the legislating of joint underwriting pools among all companies offering personal injury

liability insurance in the state. They would share the risks for total liability or, in most cases, only for umbrella policies which cover losses above some large amount, say $100,000. The second device is legalizing the establishment of physician-owned and/or hospital-owned mutual insurance associations through state medical societies or the State Hospital Associations. Many states have instituted tort reforms designed to reduce the number of claims, lessen liability, expedite settlements and to improve the defendent's relative position in contested suits.[50]

The most radical attempt to limit liability was setting voluntary ceilings in many states on the amount of recovery that is permitted, irrespective of the severity or extent of damage suffered by the patient.[51]

The malpractice problem did not derive entirely from shortcomings in the legal system or from insurance practices. It remains a fact that malpractice exists in the medical environment which might induce malpractice claims. Steps taken by states to alleviate the malpractice problem fall into three general categories:

(1) Mandatory reporting of claims and/or financial recoveries to insurance companies and/or to a state medical licensing or review board for investigation;

(2) Strengthening and/or enlarging the disciplinary powers and mechanisms of existing or newly-created boards; and

(3) Requiring periodic licensing and/or continuing medical education.[52]

Poor Patient Relations and Quality of Care -- Recognized Problems

Somers states that the contributing causes of the increase in malpractice claims are multifold. The plethora of claim instances,

even if some were without merit, lend support to the growing acknowledg-
ment that there has been a deterioration in doctor/patient relation-
ships, a failure in communication, and active or smoldering resentment
between the parties.[53]

High technology and ever more refined specialization have increased
emphasis on the mechanistic aspects of healing. They have contributed
to disregard of the patient's need for information, for assistance in
understanding his own condition and how to cope with it, for explana-
tion of the advantages and disadvantages of different procedures and
therapeutic possibilities, and for assistance in developing a sense of
responsibility for the management of his illness or disability.[54]
Additionally, there has been a persistent and increasingly documented
amount of genuine malpractice. Most studies, however, blame poor
doctor/patient relations for the increase in malpractice litigation.
According to Somers, the suit prone patient does not sue primarily
for financial gains. He is generally angry at the doctor and sues to
punish him. Most patients think of taking action themselves and only
in one-tenth of the cases did a lawyer advise suit. In just as many
cases, another doctor gave this advice.[55]

In recent years, particularly since the surge of malpractice
publicity, medical personnel have witnessed significant and salutary
increases in willingness of the profession to acknowledge and face up
to unnecessary shortcomings in quality of care and in doctor/patient
relationships. Severe admonitions from leaders of the profession are
now almost commonplace in the literature and at such ceremonies as
medical school commencement exercises.[56] At a 1974 panel discussion
among eleven of the nation's best-known physicians, Dr. John Knowles,

former director of Massachusetts General Hospital, asserted:

"There are just too damn many examples of medicine's inability to police itself. When I was in Massachusetts, the medical society was alerted to a guy doing about 80 disk operations in a year. That was as many cases as Massachusetts General with a stable of the finest orthopedic surgeons in the world was doing. Every doctor in the guy's community knew he was doing it; yet no one had complained."[57]

It is unlikely that such criticism would have been published in medical magazines fifteen years ago. According to Somers, in the five years between 1968 and 1972, 20 states had taken no disciplinary action against any physician. Within the year ending in mid-1975, six Maryland physicians had their medical licenses revoked by the Maryland Commission of Medical Discipline. This was the largest number of revocations in any 12-month period since the board began in 1969.[58]

Significant increases in disciplinary actions during 1975-1976 were also reported for New York, California and other states. The American Medical Association (AMA) announced that 20 medical societies have started programs to identify and rehabilitate physicians who are mentally ill or have alcohol or drug dependence. At least four states-- Utah, New Mexico, Nebraska and Kansas enacted disabled physician laws patterned after the AMA's model statute which responded to a House of Delegates (of the AMA) resolution in December 1975 urging legislative action on rehabilitation of disabled physicians.[59]

A survey of Illinois physicians by the state medical society produced alarming estimates that one in nine physicians in that state is addicted to alcohol or other drugs.[60]

The American College of Hospital Administrators (ACHA) has moved to impress upon its members the relationship of the conduct and care of hospitals to malpractice vulnerability. The College maintains that quality of medical care delivered can be improved by identifying and

correcting specific and potential sources of hospital malpractice common to the various medical specialties and to the hospital.[61] In 1976, medical magazines began to increasingly feature articles which departed from the earlier mode of berating lawyers and juries, and concentrated on advising doctors on the elements of their own behavior, their relations and communications with patients, that might stimulate malpractice suits.[62]

A 1976 questionaire survey of all state medical societies by the AMA asked some unprecedented questions under the heading, "Risk Prevention and Control Activities." The survey asked whether the society had an educational program in this field, whether it had an audit or assessment program, whether risk control was on the society's meeting agenda and what activities county societies were undertaking. In addition, state societies were asked to report on activities to identify and treat impaired physicians.[63]

On the insurance side, potentially the most significant development is the emergence, with legislative sanction, of doctor-owned and hospital-owned malpractice insurance carriers. In a very brief time, several of these mutual companies have demonstrated that they can provide coverage at lower premium rates than commercial carriers were asking.[64]

Many hospitals have begun to develop procedures for risk control, or risk management, with consistent reports of success, not only in financial aspects, but also in terms of patient relations. One hospital which has been using a patient grievance mechanism (which includes several of the elements of a risk management program), is the 500-bed Halifax Medical Center in Daytona Beach, Florida, which saved, according to outside analysts, an estimated $750,000 to $1 million during the period

1972-1975.[65]

Risk Management, etc.

Fifer states that because of continued expansion of the doctrine

of hospital liabilities, as well as a trend toward self-insurance, hospi-

tals have begun, in recent years, to implement risk management programs.

He writes that:

"More than 14 years have passed since the Darling Case established
the independent professional liability of institutions. Hospital risk
management programs still deal largely with 'custodial' liability (i.e.,
responsibility for the patient's safety while in the hospital), rather
than with deficiencies in medical care."[66]

Though frequent adverse effects due to custodial negligence are

usually minor and lead to minimal dollar liability, data collected

by the National Association of Insurance Commissioners (NAIC) indi-

cates that 90 percent or more of such claims are settled out of court.

Further, only 20 percent of those cases that go to trial actually result

in payment. Of claims paid in 1970, 50 percent were for less than $2,000

and only 3 percent exceeded $100,000. [67]

More importantly, risk management activities such as the creation

of procedure manuals, investigation of incident reports on a case-by-

case basis, and occasional patient satisfaction surveys have never

proven effective in preventing patients from bringing lawsuits against

the hospital.[68]

Separate and distinct from custodial negligence is professional

negligence, one cause of medically-related injuries to patients. The

risk of professional negligence is usually shared by both physician

and hospital, and is accompanied by a greater potential for large

claims and settlements. The increasing number of malpractice suits

and alleged professional negligence may simply be evidence of a legal

rights explosion in our society as witnessed by the increase in professional

liability claims against architects, engineers, attorneys and other professionals. The malpractice crisis may be a crisis of expectations generated by the romanticized portrayal of medicine by television and other media.[69]

Vaccarino concluded that the act of ordinary negligence in malpractice will occur with statistical surety in a random fashion in all our daily lives and can only be prevented by diligent conduct and by the practice of good medicine.[70] Quality assessment and risk management activities are one means of monitoring and improving patient care but to be truly effective, such efforts should be integrated within the hospital. The American Bar Association's Commission on Medical Professional Liability predicts that expanding doctrines of institutional liability will create enormous pressures on the hospital with respect to the prevention of medically-related injuries.[71]

The state of Florida has enacted legislation setting forth detailed specifications for risk management activities. Similarly, risk management program development is being encouraged by the American Hospital Association, state hospital associations, the American Bar Association and insurance companies.[72]

The Risk Management Manual of the Federation of American Hospitals states that very little evaluation of the effectiveness of risk management programs has been initiated.[73] Consequently, development of means of evaluation of such programs appears necessary.

A Need for Self-Insurance

Many hospitals and physicians could not afford the premium increases during recent years and looked toward alternative methods of protection against malpractice claims. Many hospitals and physicians began to

self-insure as an answer to this problem. Under the self-insurance concept, hospitals pay into an insurance fund in much the same way they paid insurance premiums for commercial policies. Money is set aside to pay claims and the cost of investigations. In the hospital, funding is based on previous experience with liability claims. Under a self-insurance plan, hospitals are better motivated to reduce risks and potentially harmful events. When negligence and associated claims and awards are reduced, hospitals pay less money into the insurance fund. In a sense, this has been forced upon hospitals and self-preservation and financial stability are now equated with quality assurance, safety programs and risk reduction. If a hospital can control risk, fewer accidents should occur. Patient care should improve and insurance funding should stabilize at a reasonable rate.[74]

To permit hospitals to self-insure for professional liability, three changes were required and were accomplished by 1977:

(1) Modifications in state laws,

(2) Agreement by third party payers to reimburse hospitals for self-insurance funding as they had for insurance premiums, and

(3) Access to "excess insurance policies" to protect hospitals against catastrophes. For example, hospitals can now buy "umbrella" coverage for those claims which exceed $1 million.[75]

In addition to the malpractice insurance and self-insurance programs, hospitals have become much more conscious of the need to prevent injuries to patients, visitors and employees, thereby reducing financial risk. Consequently, quality assurance and risk management activities have been emphasized more frequently as appropriate means of identifying and preventing problems or injuries before they occur. Mechanisms

have also been established within the hospitals to respond to problems or injuries that may precipitate malpractice suits after they occur. If such quality assurance and risk management activities are planned carefully and used appropriately, the total risk management program can be a viable, effective method of preventing injury and reducing financial loss. The impact of such a program will, however, only be as great as staff training is comprehensive, and as program evaluation modifications are continuous.[76]

Mount Sinai Hospital in Chicago was faced with three alternatives in 1976 regarding its malpractice insurance program:

(1) Pay $2.3 million to get $6 million in coverage,

(2) Put $3 million in escrow to cover insurance costs and buy $3 million of umbrella coverage, or

(3) Become a self-insurer.[77]

During the past 14 years, the 500-bed facility had paid only $500,000 in malpractice claims. The hospital elected to self-insure and increase its emphasis upon the hospital's internal risk reduction program--a decision which resulted in considerable savings to the hospital during its first year of operation.[78]

Many hospitals and hospital systems have met with success in risk management efforts. In 1975, the North Broward Hospital District found itself tasked with a situation in which the question of malpractice insurance had become a very intense and complex problem. This district covers the northern two-thirds of Broward County, which has a population of 600,000. The district had been inviting bids for total insurance coverage, including malpractice coverage, every three years for 15 years.[79]

In June 1973, the hospital received bids and was disappointed to

learn that only one insurance company had submitted a bid for public liability and malpractice coverage. The bid, which was for three years with an annual premium of $370,000, was 48 percent higher than what it had been the previous year. The hospital accepted the bid thinking satisfactory coverage was provided for the next three years. However, early in 1975, a series of adjustments was made by the carrier which quickly brought the asking premium to $2.5 million, or an increase of 575 percent in less than 20 months.[80]

This premium increase would have required an increase in patient room rates of approximately $6.00 per day to meet malpractice alone, and the hospital believed that such an increase to its patients for malpractice coverage was unjustified. [81]

In the limited time that was available to the hospital before the premium was due, many insurance possibilities were studied; however, the investigators discovered that coverage was too costly, undesirable or simply not available. Meanwhile, the hospital attorneys were investigating the possibility of self-insurance and they ultimately concluded that it would be in the district's best interest to set up its own insurance program. The program's stated objectives were to ensure that the district and the hospitals received full protection for malpractice and public exposure to liability, that all the political statutory requirements were met, that there was a well-defined procedure that ensured timely processing of all incidents and claims, and that claims prevention was emphasized. [82]

Responsibility for the program was delegated by the board to the insurance committee made up of three board members, a hospital attorney, the district director and the three hospital administrators. This

management program included a detailed system of evaluating and re-
viewing each occurrence involving a patient, a visitor or a physician
from which some injury or problem might result.[83]

In describing the new malpractice coverage of the non-insurance pro-
gram, the hospital strived to emphasize to attorneys, patients, the
general public and juries (to the extent permissible) that they had
no malpractice insurance. Any settlements, judgments or other payments
granted to patients had to be taken from a limited tax fund. They
wanted juries to understand where the monies came from. Because most
of the jurors would be tax payers, the hospital felt that the jury
would base their judgment on facts rather than emotions.[84]

Another important aspect of the new program was the effect it had
on employees. In the past, the fact that the hospital had insurance
seemed to lull employees into complacency and they were much less con-
cerned about malpractice problems. As a result of the program, they
began to view the risk management program as their own and to recog-
nize the fact that the funds set aside could be used in either of two
ways: (1) to pay malpractice awards, or, if they do a good job and the
district has a good malpractice experience, (2) to pay for increased
employee salaries and benefits.[85]

In order to satisfy the concerns of those who held the hospital's
outstanding revenue bonds, the hospital set aside $1 million in a special
reserve account for this purpose. These funds could be used to sat-
isfy judgments, but the hospital was required to maintain this amount.
The hospital planned to increase this fund to $2 million as quickly
as possible.[86]

After 18 months experience under the "non-insurance" program,

the hospital was very pleased with the results. After the first full
year of operation, the total cost of the program including attorney
fees, salaries, settlements, and other expenses, was only $61,000.
Based upon the insurance company's demand of $2.5 million, it adds up
to a savings of more than $2.4 million to the hospitals' patients in
the first year. Moreover, the interest earned on the $1 million
reserve covered the entire cost of the program during the first year
of operation. [87]

Hospital-Sponsored Insurance Groups

For several years, commercial insurance companies found the pro-
fessional liability market to be profitable, and competition held
insurance premiums at reasonable levels. However, the increasing
number of malpractice claims, the increasing costs of awards and
settlements, and decreases in investment income, stock market losses
and better insurance opportunities in other areas, caused many compan-
ies to withdraw from the professional liability market place. Many of
the commercial companies that have remained in the professional liability
marketplace modified their medical malpractice coverage and underwriting.
Premiums are high; they are based on pessimistic projections of incurred
but not reported claims, expected losses, and margins for error.[88] Many
companies have set premium rates to cover all expected losses, opera-
tional expenses and profits, without consideration of investment
income or other assets as resources for payment of claims and these
other expenses.[89] Some companies have changed their forms of coverage
from occurrence coverage to claims made coverage. As a result, every
state in the nation has enacted remedial legislation designed to lower
these costs or improve availability.[90]

More than 40 special-purpose companies have been formed. They range from companies that are owned or sponsored by hospital or physician associations to companies that comprise a few providers. Such companies include Hospital Sponsored Insurance Organizations (HSIO), which are insuring organizations that are owned and/or sponsored by the parties insured or by a group of associations to which the insured individuals belong. [91]

Currently there are 28 HSIOs, 20 of which are located in the United States. HSIOs are formed to best suit the requirements of the insured parties and the state governments.[92] There are certain advantages provided by HSIOs which include increased stability of insurance coverage and costs, additional capacity, more effective loss prevention and risk management programs, and reduced operational costs.[93] HSIOs can stabilize fluctuations in coverage and costs. As HSIOs operate solely for the protection of their members, the unilateral cutbacks in coverage and increases in premiums made by commercial carriers are avoided. The result is availability of coverage at reasonable costs based on local or statewide experiences, an important advantage to these participants.[94]

Another advantage of HSIOs is that commercial companies have reduced their capacities by restricting the amount of exposure to malpractice claims that they wish to assume, and thereby fail to meet the current demand for higher limits of coverage put on them by hospitals. HSIOs can generate new capacity provided that sufficient capital is produced by the members to meet the HSIO tests and provided that appropriate re-insurance arrangements can be made for the added protection of their insured.[95]

Loss prevention and risk management programs conducted under

auspices of commercial companies have been somewhat ineffective. HSIOs, which have the unique relationship with their insured, face less resistance to loss prevention and risk management programs, and have a better chance of implementing effective ones.[96]

Operational costs of HSIOs can be held substantially below those of commercial companies. Additionally, Medicare will reimburse hospitals for premiums paid to HSIOs as long as the premiums do not exceed the cost for available comparable commercial insurance and as long as they meet the Medicare program's provisions regarding reasonable cost.[97] Although risk management should be pursued by all hospitals, it is especially important for hospitals who use self-insuring mechanisms to incorporate risk management activities and self-insurance programs. It is important for two reasons. First, risk prevention activities, both for reducing the possibility that patients will be harmed during their hospitalization and for providing for increased visitor, employee, and physical plant safety, can in the long run produce cost savings for hospitals.[98] Second, the Medicare Bureau requires the self-insuring hospitals, whether they use limited purpose (captive) insurance companies or self-insurance funds as their self-insurance mechanism, to have risk management programs, if they wish to have their premiums or fund contributions treated as allowable costs.[99]

"Risk Management" is a term borrowed from the insurance industry during the malpractice crisis. Long before the term was applied to hospitals and health care, hospitals were practicing risk management through the aseptic practice, safety, and tissue committees of medical staff, as well as through those committees concerned directly with admission privileges and clinical practice of medical staff physicians.[100]

Risk Management -- A Recognized Need

Because of the magnitude of the malpractice problem, the W. K.
Kellogg Foundation of Battle Creek, Michigan, recently awarded the Idaho
Hospital Research and Education Foundation a $627,000 grant to develop
a cooperative risk management program jointly with the Colorado and
Arizona Hospital Associations, which is designed to reduce hospital
insurance losses and encourage injury prevention. This three-state
coalition is perceived as having great potential to reduce malpractice
and negligence insurance claims and premiums; improve hospital safety;
encourage the enforcement of necessary regulations, standards and codes;
and enhance the quality of patient services in the western region of the
United States.[101]

Key functions of this risk management program will be:

(1) Identification and analysis of potential risk;

(2) Elimination of risk incurring activities;

(3) Implementation of procedures and programs to prevent and
reduce injuries and loss; and

(4) Evaluation of methods to best pay for losses incurred.[102]

During the three-year study, the cooperative program will be
implemented in 32 hospitals of different sizes, locations (rural and
metropolitan), and type (community, governmental, and teaching).[103]

The cooperative risk management program has the potential to
eventually be implemented in approximately 222 hospitals already
participating in related programs in the three states.[104]

Pilot hospitals will be requested to make certain commitments as a
part of the study. They will receive approximately 85 man days of
technical service at no cost during the twelve-month pilot phase.

Additionally, they may expect reduced incidents and losses leading to reduced costs as a result of implementing the risk management system.[105] For a detailed study of the risk management approach to be utilized in this pilot study, see Appendix B.

There are several factors to consider when talking about risk management in the Hospital. Progress toward the institution's goal of higher quality care through expanding technology is blocked by cost containment efforts. Efforts to monitor the quality of care mandated by legal requirements for corporate responsibility are met, in some cases, with other legal decisions mandating due process in medical staff admission, privileges and practice procedures. Further, there is a changing image of health care. Much has been written about the transition of the hospitals from the physicians' workshop of yesterday to the community health center of today. The patient has changed from the "trusting, paying, medically ignorant sick person to the doubting, fully insured, knowledgeable consumer."[106] Additionally, government, besieged by the high cost of Medicare, Medicaid, and research and development programs, threatens to redirect the expensive taste of the public in favor of a stripped down model of prevention and cure. All this is to be accomplished at the same time that hospital costs are being raised by inflationary, economic, and societal forces over which hospitals have little control.[107]

Finally, trustees should understand that risk management is a joint venture, or partnership with the governing board and medical staff. With about 80 percent of all claims paid to patients resulting from occurrence in the hospitals, this partnership is extremely important. The securing of evidence by patients' lawyers alone involves hospital personnel who should be aware of legal implications.

Another factor to be considered is that risk management programs are required for state licensure in a growing number of states. The hospital is required to have an acceptable program in order to qualify for Medicare and Medicaid reimbursement of payment for the self insurance reserve fund. In addition, the accreditation standards of the Joint Commission on Accreditation of Hospitals already specify most elements of the risk management program and are coming closer and closer to requiring a formal program of risk management. [108]

According to Stewart, hospitals developing risk management programs should keep in mind the following considerations:

(1) Individualization of risk management programs is essential to success.

(2) The elements of risk management programs should be flexible; the one exception being some degree of organization.

(3) How to organize for the control of risk in a given hospital depends on the risks that can be identified, interpreted, and isolated in the hospital.

(4) Any system of risk management should be adopted by the governing board.

(5) Designation of a risk manager charged with the responsibility for the system is necessary to insure accountability.

(6) A risk management committee should be formed that is suitable to the hospital and its management style with persons respresenting the governing board, the medical staff, nursing services, and the patient.

(7) All persons on the hospital premises can contribute directly or indirectly to the patient's adverse response to a hospital stay.

(8) The greater the number of providers that are involved, the

more effective the risk management system.

(9) The objectives and procedures of risk management should be stated in sufficient detail to give direction to the program and to permit it to be evaluated.

(10) The system should have a suitable means for the identification of risk and an interpretation of its cause and effect on patient care delivery.

(11) The incidence of risk needs to be isolated in terms of particular hospital procedures, location on the premises, and the groups of personnel involved.

(12) Finally, the system must include a way to methodically follow the reduction and eradication of risk for patients. This can best be accomplished by collecting the information about risk. Such collection, whether by pencil or computer, can help immeasurably to locate trouble spots as they occur in order to facilitate education and prevention.[109]

Once defined and systemized, risk management needs to become a way of life and a factor in decision making. Decisions about spending should be reached not only in terms of patient revenue but in terms of quality of care. Settlement of patient claims should consider not only dollar cost but also physician and nursing staff involvement in decision making and how patient care should be modified as a result of the experience.[110]John L. Ashby, et al, stated that the primary mechanism available within the health care setting to deal with skyrocketing liability costs is risk management. Beyond the economic burden and the reality that the majority of malpractice claims arise from hospital based incidents, hospitals will be receiving increasing pressure to reduce risks for other reasons which include the following:

(1)   Increased legal responsibility that is being assigned to hospitals for care delivered within the hospital.

(2)   Increased use of self-insurance and the fact that Medicare requires a risk management program for self-insuring hospitals.

(3)   Increased consideration of the proposal that hospitals assume all liability and responsibility for insurance (including that of physicians) for malpractice incidents occurring within the facility.[111]

The primary elements in risk reduction according to Ashby, et al, are:

(1)   Prevention of claims: mechanisms established or proposed for averting the claims that may result from known maloccurrences (e.g., prompt treatment of injuries at no cost to the patient).

(2)   Defensive claims: procedures to evaiuate the efficacy of court defense and to assure the adequacy of defense if this course is chosen (e.g., use of expert medical opinion in determining the existence and extent of negligence).

(3)   Disposition of claims: procedures for the legal disposition of outstanding claims (e.g., out-of-court settlement).[112]

Ashby, et al, identify nine risk detection procedures. Incident reports alone, they state, are not adequate for risk detection because it cannot be assumed that all incidents will be reported. In particular, physician-related incidents are rarely reported in this manner and these are the cause of many serious malpractice claims. Several other potentially useful sources of information are available to hospitals including the following:

(1)   Incidents reported verbally by physicia- s and employees;

(2)   Patient complaints to employees, administration and business office;

(3) Patient ombudsman findings;

(4) Letters from attorneys about injuries or other cases of
patient dissatisfaction;

(5) Malpractice claims;

(6) Summaries of past claims experiences or the experiences of
other hospitals;

(7) Inspections of the physical plan and audits or policies and
procedures such as relevant portions of the Joint Commission on Accred-
itation of Hospitals accreditation report;

(8) The experience of employees and physicians; and

(9) Findings of the medical audit or other quality assurance
committees.[113]

Ashby, et al, further stated that as many mechanisms as possible
for reporting physician related incidents should be employed in order to
provide every opportunity for physicians and employees alike to make
reports on quality control procedures.[114]

The proper handling of incidents of potential liability is based
on two philosophies. (1) immediate open and honest discussion of the
incident with the patient and relatives; and (2) fair compensation for
any harm to the patient that is believed to be caused by the hospital.[115]

Staff Level Functions

In general terms, according to Ashby, et al, there are six staff
functions which are within the scope of a patient-oriented risk reduc-
tion program:

(1) Receipt of information on patient incidents from all applicable
sources;

(2) Logging, tabulation, filing, and transmittal of information on

incidents obtained from reporting sources;

(3) Investigation of incidents to provide information for both development of legal positions on specific cases and development of preventive strategies;

(4) Screening of cases for consideration by committees and other individuals for liability control and prevention purposes and providing follow-up committee actions as requested;

(5) Liaison with patients (patients' relatives and attorneys, as applicable) for purposes of preventing a claim from being filed and coordination of efforts to make financial restitution when that is necessary; and

(6) Development of recommendations for compensation to aggrieved patients (which may or may not require administrative approval). [116]

The risk manager is an integral part in any risk management program. The American Hospital Association's own version of a position description for the risk manager is provided at Appendix C.

Ashby stated that there are fourteen model elements for risk management programs, of which six are considered most important:

(1) Single administrative responsibility for the program;

(2) A series of risk reduction procedures, including analysis of incident reports, patient complaints, patient ombudsman findings, letters from attorneys about injuries and malpractice claims, inspections of the physical plant, and audits of policies and procedures;

(3) Written liability and control procedures;

(4) Delineation and assignment of staff level functions;

(5) A centralized committee to coordinate risk management activities;

(6) Encouragement of physicians so that they will report incidents

as well as examples of poor care. [117]

Fifer states that medically related incidents or events will be the main target of risk management programs. Physicians and nurses must become actively involved in such programs. Coordination of existing quality assurance activities with those designed for risk management may be the first and one of the most effective steps in improving a hospital's risk management program. [118]

Many hospitals have met with success through development of risk management programs. Largely as a result of risk management programs being implemented in hospitals, more than 1400 hospitals and physicians in Florida will benefit from a $2.2 million reduction in medical mal-practice insurance premiums approved for the Florida Medical Malpractice Joint Underwriting Association. Hospital facilities including clinics, blood banks, laboratories and seven HMOs will realize a 19.6 percent savings, or approximately $1.2 million. In Florida, the patients com-pensation fund of $27 million in reserve is used to pay claims which exceed $100,000. The individual practitioner or facility is required to cover the first $100,000 of any claim. [119]

The American Hospital Association and other authorities on risk management advocate the systems approach to development of risk manage-ment programs. A real benefit of the systems approach to risk manage-ment is a potential reduction in professional insurance premiums. The American College of Surgeons reports that the Pennsylvania Hospital Insurance Company, which insures 185 hospitals, reduced rates by 9 percent the first year after instituting the systems approach in its hospitals. [120] Further, the Virginia Hospital Reciprocal offers a 10 percent discount on premiums to hospitals that have a systematic risk

management program. In Washington State, risk management by the 70-hospital insurance trust reduced premiums to 30 percent below the commerical rate; and the systems approach used by 53 Adventist hospitals has helped them reduce the premium by 20 percent.[121]

Donovan and Bader advocate the systems approach to risk management. They state that the essential elements in a risk management program are people, especially:

(1) the medical director and/or department chief who maintains strong methods of education, supervision, privileging and audit;

(2) a chief executive officer who is committed to quality care and has designated a top-level assistant as risk manager;

(3) a board that supports the quality assurance efforts of administration and medical staff, and

(4) nursing supervisors, patient representatives and other personnel who have specific responsibilities for bringing the benefits of the system to its primary recipients--the patients.[122]

Donovan and Bader further state that without the cooperation of those key persons, no risk management program can hope to achieve maximum effectiveness.[123] Hospitals involved in risk management programs have shown that stronger systems resulted when the medical staff was consulted and briefed during the planning stages of organizational models.

Donovan and Bader introduced four risk management organizational models (See Appendix D). No one organizational model is right for every hospital. Many hospitals utilize a general organizational model which was adapted to their individual requirements. Alternative models discussed by Donovan and Bader are examined below:

(1) The Medical Director Model I. The medical director who reports

to the chief executive officer directs the risk management office where all administrative safety programs are centered. He also chairs the medical staff patient safety committee. Existing medical staff committees on quality assurance and peer review report to the risk management committee which coordinates their activities and integrates them with hospital-oriented programs.[124]

(2) Medical Director Model II. The medical director oversees all medical staff quality assurance programs and coordinates his activities with a separate administrative risk management office through a risk management committee. The committee's members are drawn from both administrative and medical staffs (e.g., chief executive officer, director of nursing, director of engineering, department chiefs and committee chairmen).[125]

(3) Quality Assurance Model. A quality assurance director, who may be a physician or a non-physician, directs all hospital and medical staff programs from one office and communicates with the medical staff through a risk management committee composed of medical staff members.[126]

(4) Administrators/Department Chiefs Model. This a minimal change model in that no risk management office (or no new office) is created. A top-level administrator directs or coordinates hospital activities that involve patient safety (e.g., patient relations, incident reports by nurses). The hospital that developed this model had full-time department chiefs, however, the model could also work for hospitals having part-time or volunteer chiefs who have enough time and a commitment to the risk management system.[127]

A feature central to all four models is a medical incident committee or some similar control that reviews and takes action on

incidents which are serious enough to require immediate response.
The members of this committee might be the medical director, the chief
executive officer and the appropriate chiefs of services. Most of the
work of any risk management program is carried out by the risk manager
and the risk management committee, whose members are drawn partially
from the medical staff. The coordinator may or may not be a physician.
Sometimes he is an attorney who serves as the hospital's in-house coun-
sel. [128]

The specific responsibilities of the risk manager include the
following:

(1) Reviewing incident reports and other patient safety informa-
tion (e.g., reports of the patient representative on conditions that
might lead to incidents or claims), and bringing together hospital
and medical staff for corrective and preventive actions;

(2) Building a data base of incidents (cross-referenced by severity,
type, location in the hospital), and other relevant factors, for use
in identifying events that may require corrective action;

(3) With the help of the risk management committee, encouraging
physicians to report incidents (either verbally or in writing) and
personally encouraging nurses and other hospital employees to report
incidents;

(4) Through educational programs, increasing awareness of factors
in patient safety among the medical staff and all other hospital per-
sonnel;

(5) Identifying critical patient safety problems for review and
action by the medical staff committees on audit, credentialling, con-
tinuing medical education, and other quality assurance activities;

(6) Following up on actions recommended by the risk management committee to ensure that they are timely and actually completed.[129]

Appendix C is a position description for the risk manager as seen by the American Hospital Association.

The specific responsibilities of the risk management committee, as seen by Donovan and Bader, are as follows:

(1) Reviewing critical incidents and patterns of incidents, and agreeing on appropriate actions;

(2) Coordina .ng the efforts of the medical staff committees on audits, credentialling, continuing medical education, and other quality assurance activities; and

(3) Ensuring that programs exist which focus on education and prevention rather than on corrective actions.[130]

Benefits

The greatest benefit to the physician of the systems approach to risk management is helping him improve the quality of patient care. This system promotes improved care by detecting problems quickly, creating lines of accountability for action, strengthening existing quality assurance mechanisms and detecting professional incompetence. When all quality assurance reporting mechanisms are coordinated through the risk management office, the risk manager can screen data immediately for such danger signals as an unusual number of falls or postoperative infections. Types of incidents can be detected as they occur instead of months later when the insurance carrier provides data. Potentially Compensable Events (PCEs) (i.e., incidents that could result in claims against the hospital), can be identified through concurrent review of

patient charts instead of through retrospective audits. An incident or complication involving physician care can be identified and corrected before a minor problem becomes a serious one. In the long-run, a reported incident can become a part of the continuing education process that contributes to better patient care.[131]

Implementing Risk Management

According to Donovan and Bader, an action plan for the systems approach might include the following steps:

(1) Build awareness of the patient safety problem and of the systems approach as a partial solution;

(2) Encourage hospital and medical staff to make a joint commitment to the concept of a systems approach;

(3) Delegate a top-level hospital physician group to draft an organizational model and audit the hospital's existing quality assurance systems to see how they can be strengthened and integrated;

(4) After a complete audit, implement the system carefully, one step at a time;

(5) Evaluate and continue to evaluate (and make changes, if necessary) in the best interest of the patients and the hospital and then the physician team (in that order of priority).[132]

In a seminar conducted by the American Society for Hospital Risk Managers in New Orleans in March 1980, Janine Fiesta identified three basic steps in a risk management program:

(1) Identification of risk utilizing:

(a) Claims histories /incident reports regarding malpractice;

(b) JCAH, state and similar surveys conducted;

(c) Patient Complaints from patient representatives and the

business office;

(d) Committee minutes (Infection Control, Safety, Utilization Review, Mortality and Morbidity, etc.);

(e) Medical Records: Utilizing concurrent screening and attorney requests; and

(f) Oral Communication, especially from the physicians and nurses.

(2) Evaluation, which may include a complete investigation to see if the hospital conformed to standards;

(3) Treatment: To eliminate causes of malpractice problems (through education, policy and procedure changes, communication, better documentation, etc.).[133]

A detailed study of the steps to be taken to implement a hospital risk management program utilizing the systems approach is provided at Appendix E.

The Lawyer's Role in Risk Management

Many hospitals employ legal counsel but most hospital staff lawyers devote the major portion of their time to the business aspects of hospital management (e.g., certificate of need applications, Medicare and Medicaid problems, labor disputes), rather than to medico-legal issues involving patients.[134] Because few hospitals employ a lawyer who handles patient care issues on a full-time basis, the medical staff and administration may not fully understand the lawyer's capacity for preventing and/or minimizing legal problems for the institution.[135]

A good risk management program should incorporate legal counsel as a part of that program. Holder cites three functions of the Hospital attorney:

(1) Investigation of, and representation in, malpractice suits;

(2) Prevention of lawsuits; and

(3) Education of hospital personnel.[136]

When an event raises the threat of a malpractice action, an in-house lawyer can help alleviate much of the difficulty, even if the hospital is insured by a commercial carrier. For example, in a teaching hospital, house physicians involved in the care of a patient may be practicing elsewhere by the time a malpractice suit is filed. Therefore, the lawyer who is immediately informed of an incident can obtain statements from the parties involved and investigate the situation long before a suit is filed. When working with representatives of insurance companies, an attorney can also expedite necessary arrangements, give legal advice if requested, and be available to analyze the problem and its legal implications.[137]

Holder states that the large hospital has enough patient-related issues of this type to keep at least one full-time lawyer extremely busy. Small hospitals might consider sharing the services of a lawyer.[138]

Teaching is another very important aspect of an in-house lawyer's role. Through regular meetings with legal counsel about the common problems and issues (e.g., consent forms, informed consent process, treatment of minors, emergency care, attending physicians), nurses and other hospital personnel learn to recognize a legal problem when it occurs. Most risk management issues involve, in some way, potential legal problems. The wisdom of trying to manage legal issues without a lawyer on staff is questionable.[139]

Hospital Policy

Hospital policy plays an important role in risk management. For

example, both the hospital and the delivery room physician were held liable by the California Court of Appeals in a suit charging them with causing emotional distress in a husband who witnessed both his wife's and child's death in the delivery room. In announcing its decision, the appellate court majority threw out the previous standard, which exempted the hospital from emotional distress liability when an observer witnessed unpleasant or disturbing events in an operating room or delivery area. The husband's allegation that the hospital caused the wrongful death and breached a contract to deliver the child were dismissed by the court. As a result, the husband would have had no grounds for a suit if he had not been allowed in a delivery room.[140]

Physician Participation

Physicians can identify and correct problems that keep patients from getting the best care possible. Many of the problems physicians uncover can be traced to the deficiencies in the facility, its equipment or the way care is organized and delivered. Others, however, can be traced to people failure--to the fact that a physician lacked the knowledge or skills or proper attitude to perform at the highest level. Fifer defines risk management as a detection system designed to predict when the next person failure will occur and to prevent it from happening.[141]

Not surprisingly, physicians are a major component of a total hospital risk management program. A risk management program cannot eliminate every risk (many patient care activities, even if performed in the most careful manner, are inherently risky, and sometimes harm to the patient is done). Even when harm occurs, however, liability

suit may not result if the patient was adequately informed of the

risk and if he consented to performance of a procedure.[142]

A risk management program can prevent liability by detecting

carelessness and negligence before they occur.   Experience shows

that liability suits are often preceded by a clearly identifiable

trail of substandard performance or behavioral aberration.[143] If it is

detected and corrected in time, serious harm to patients can be pre-

vented. The organized medical staff is responsible for developing

a detection system designed to prevent harm caused by physician care-

lessness.

According to Fifer, a physician's responsibility for risk manage-

ment has four components:

(1) Initial credentialling. The medical staff is responsible

for recommending only qualified physicians for medical staff member-

ship, and for recommending for each physician specific clinical

privileges limited to his area of competency. Conscientious staff

work before the appointment decision is made may prevent liability in

the future for both the hospital and applicant.

(2) Recredentialling. Accreditation standards state that the

current competence of each member of the medical staff must be appraised

on a periodic basis. In every instance, recredentialling decisions

should be based on the subjective evidence gleaned from the performance

evaluation or audit system.

(3) Other internal data sources. Data related to the quality of

patient care may arrive from any review and evaluation activities within

the hospital. A safety committee may detect an electrical problem in

the patient monitoring equipment before harm is done. The infection

control committee may spot an outbreak of infection before it becomes wide-spread. The tissue committee may discover a trail of questionable surgical judgment before death on the operating table occurs. The transfusion committee may discover indiscriminate blood uses that point to an increased danger of serum hepatitis. The utilization review committee may detect a pattern of overstays due to a potentially preventable complication such as pulmonary embolism or infarction.

(4) External data sources. The medical staff needs a reporting system whereby staff physicians will promptly disclose any malpractice actions filed against them even if those actions were unrelated to the hospital. Prompt investigation may forestall a serious hospital incident and the resulting liability. The medical staff also needs to receive data produced by the county medical society and the state board of medical examiners, both of which often receive and investigate complaints about physicians.[144]

Specific techniques are needed to encourage both physicians and employees to accept the responsibility to report incidents and to perform their work in a manner that will avoid cause for legal action. The most difficult aspect of this charge may be to get staff physicians to report incidents in which they are personally involved or of which they may have knowledge. Physicians are reluctant to report incidents not only because they dislike the added paperwork or time required to discuss the matter, but also because they feel the information may contribute to the probability of legal action against them or their colleagues.

Ashby, et al, state that this attitude must be changed. Education is the key to changing attitudes, particularly in the community hospital setting.[145]

Two points should be stressed in the educational process. First, knowledge of incidents before they result in claims is the key to successful handling of potential liability from the perspective of both the physician and the hospital. Second, it should be made known that the information will be held confidential from outside parties and the rest of the medical staff.[146]

A useful tool that can be utilized in working with physicians in gaining their support of the risk management program is provided at Appendix F.

Training

Although much has been written about the role of the hospital risk manager, lawyers, physicians, etc., little attention has been given in the literature to specific training models for risk management. However, the South Carolina Hospital Association (SCHA) developed a successful training program. The SCHA, in cooperation with its insurance consultants and the Carolinas Hospital and Health Services, Incorporated, conducted a series of four regional seminars on this subject. The seminar participants were given instructions to enhance training and education efforts in risk management. They reviewed a series of slide/tape programs that dealt with specific needs, based on valid problem analysis.[147]

Risk managers have little knowledge about training and educators know little about risk management. Specific problem areas and factors which the risk manager must be aware of, and in which training should be accomplished in the hospital are:

(1) Falls and medication errors are the most frequently reported incidents;

(2) Incident report forms are not always completed correctly, and improperly completed forms cannot be analyzed for trend data;

(3) The most serious incidents occur in the operating room, the recovery room or the emergency department;

(4) Hospital personnel repeatedly ask for more information about the legal aspects of their work;

(5) Loss control surveys point to a need for more information on equipment safety; and

(6) No clear models for risk management training programs exist.[148]

Training and education can provide information, change attitudes or alter behaviors relative to problems that have been identified through the risk management process. If the risk management process identifies deviations from ideal or acceptable standards, training can ensure that the persons who are deviating from standards have the basis for change. However, training and education may not change the supervisor's function as a role model.

Physical or fiscal constraints may be causing a problem and/or internal issues may alter training outcomes or management response to a problem. Training is not a panacea; rather it is a specific technique that provides intervention when a particular problem has been identified.[149]

Infection Control

There has been a great deal of recent emphasis placed upon hospital infection control programs. The National Safety Council, in its Health Care Newsletter, dated January 1980, reported that the goals of hospital infection control programs should be to:

(1) Identify the susceptible individuals and protect them before

they acquire an infection;

(2) Identify spreaders and vehicles of bacterial or viral diseases and segregate them before they disseminate an infection, and

(3) develop a knowledge of the working conditions under which personnel care for patients so that infection is not transmitted from personnel to patient, from patient to patient, and from patient to personnel.[150]

Documentation of hospital-associated infections is necessary to establish a base-line for an institution and for specific medical services and nursing units. Once a base-line is established, any evidence of a problem or a potential problem can be readily seen.[151]

The hospital has a responsibility for infection control. This includes orientation of all new employees on the importance of infection control, personal hygiene and their responsibility in the infection control program. Another aspect is documented in-service education for all departments and services, relative to infection prevention and control.[152]

There are specific areas in which hospitals may be found liable as a result of infections:

(1) Infections caused by equipment and faulty techniques;

(2) Contact with infected patients;

(3) Hospital personnel as a source of infection;

(4) Notifying patients of the presence of infection (or failure to do so);

(5) Negligence of personnel and staff (such as breaking aseptic procedures); and

(6) Discovery and treatment of infection cannot always be traced to a negligent act of the hospital, yet the hospital may be held liable for harm that results from infection if the hospital does not meet the

standards of a good practice that would have caused the infection to be recognized.[153]

Patient Relations

Sax states that humanistic health care and patient relations are integral parts of a hospital risk management program, especially because these issues have become major considerations in recent medical malpractice cases. Potential risk of injury to patients while they are receiving care must be identified, evaluated and treated. The hospital's ultimate objective is, of course, to eliminate any risk of injury to patients. However, the hospital is a high-risk environment and provision of medical care is a high-risk activity. Therefore, when prevention of all risk is impossible, hospital personnel should seek to reduce the frequency and severity of patient injury.[154]

While advanced technology has made many high-risk procedures possible, it has decreased the human element in health care. At the same time, the incidence of malpractice cases has increased, largely, as a result of better informed, more demanding health care consumers and unrealistic expectations for dramatic treatment outcomes.[155]

A 1977 report of the American Bar Association's Commission on Medical Professional Liability emphasized the connection between litigation and patient-provider relations. It said that claims may be reduced dramatically by paying closer attention to patient relations and the quality of medical care.[156]

According to Sax, communication is the key to creating an environment where both the physical and emotional needs of patients must be met. The patient relations component of a risk management program makes the hospital more responsive to the emotional, as well as,

physical needs of patients.[157]

Gekas writes that a hospital patient relations program can provide information about potential risks at a very early stage. Further, some states and federal agencies already require health care institutions to have a procedure for handling patient complaints. Such efforts are an essential part of a risk management program.[158]

Documentation

According to San Diego defense attorney R.W. Harlan, because the medical community does not understand the use of medical records in the court room, hospitals often end up paying sizeable settlements merely because they cannot disprove liability.[159] Harlan suggests that the hospital administration stress the use of medical records as a defense tool. If a patient is uncooperative or unruly, that should be documented in the medical record. The record is not just a plaintiff's record.[160]

Harlan states that:

"Records that are sloppily completed and inconsistent can damage the hospital's case. The plaintiff's lawyer can point out the medical record as a reflection of the kind of care the patient received. Sloppy records to a jury indicate that the care was sloppy."[161]

All medical treatments administered to the patient should be documented on the patient's record. Notation of machine or equipment failure and the time of failure can help a hospital transfer liability to the manufacturer or some other responsible authority. Chronology of events is the most crucial element of record keeping.[162] In the case of litigation, the time-frame can be critical. Emergency situations, such as cardiac arrests, find the staff completing a series of procedures in a short time-frame with no chance to make notes or check the clock. In this situation, attorneys recommend that medical

professionals simply note the time the procedures began[163] For instance, the entry on the chart should state: "At approximately 2 p.m., the following events began to occur." Then the physician or nurse can compile the notes after the procedures have been completed and list the events that have taken place. Notation of the time the procedures concluded should follow.[164]

Harlan believes that the medical record should serve three distinct and equally important functions:

(1) As a record of the facts, not opinions, relevant to the treatment of the patient;

(2) As a risk management tool; and

(3) As documentary evidence that stands by itself.[165]

For a detailed study of the role of medical records management in risk prevention, see Appendix G.

Incident Reporting

The magazine, Hospital Risk Management, reports that no matter what the hospital's bed size or budget, a comprehensive incident reporting system is essential to the success of a cost-cutting risk management program.[166] Further, there are five common pitfalls with most incident reporting systems as follows:

(1) Failure to file a report;

(2) Failure to complete reports properly;

(3) Incorrect routing of reports;

(4) Failure to activate immediate correction; and

(5) Failure to plan long-range prevention strategy.[167]

According to Hospital Risk Management, many incidents are not

reported because some employees may fear the report will be used as a disciplinary tool on them or will be a mark against them in their record. Other employees simply may not understand the importance of the incident report and the necessity to submit a report on each incident.[168]

To avoid this pitfall, administration should make sure that completion of the reports will not result in any kind of punitive measure or any sort of negative reflection on anybody. Explaining the use of the incident report so that the hospital staff can also realize the importance of the report as a tool in risk management can help.[169]

At Kennestone Hospital in Marietta, Georgia, the problem of getting the facts was resolved by hiring a former policeman as risk manager. After the form was completed, the risk manager interviewed the person involved and advised them that only the facts pertinent to the event should be included in their statement.[170] The interview also reinforces with the employee the importance of filing the reports and completing the reports properly.

The problem of properly routing the incident report was resolved at Lennox-Hill Hospital in New York City by incorporating a box in the lower left-hand corner of the form itself which indicates exactly which staff members will review the form and in which order the reviews will take place.[171]

Hospitals which are managed by the Hospital Corporation of America forward all incident reports regardless of severity of the incident, directly to the insurer. This policy eliminates hospital-level decisions regarding possible liability.[172]

To ensure that immediate action is taken, Kennestone Hospital

employs a safety inspection follow-up memorandum, which alerts individual

departments in the hospital that the risk management office has found

a deficiency in that area. The form states, basically, what the problem

is, that it can be corrected, and that top management at the hospital

expects the department to correct the problem. The deficient depart-

ment responds, utilizing another section of the same form, listing

the specific actions which the department took to correct the problem.[173]

When hospital employees complete an incident report at Lennox-

Hill Hospital, they usually complete a request for work order to cor-

rect the problem immediately. Where a change in policy or procedure

is indicated, the risk manager calls the matter to the attention of

the nurse or other individual who is responsible for the department or

for the specific procedure or policy. If a change is necessary, a

notice is published in the semi-monthly hospital newsletter which is

given to every nurse in the facility.[174]

Hospitals managed by the Hospital Corporation of America manage

problem-correction on an individual-hospital-basis. If no correction

is made and another incident occurs, the matter is brought to the

attention of the hospital's insurance company, which results in immediate

investigation by the insurer.[175]

According to Lennox-Hill Hospital, there are three uses for the

incident report:

(1) As an investigation and claims tool;

(2) As a reporting and statistical tool; and

(3) As a prospective correction tool.[176]

A good incident reporting system, according the risk manager for

Lennox-Hill, will ensure that the reports are used in all three ways.

If a hospital is not using the reports in all three ways, the hospital

is probably not getting optimal results from the forms.[177]

Tactics for Coping with Potentially Compensable Events (PCEs)

Even in the best risk management programs, there are times when

preventive measures fail to do the job. Often a PCE will occur.

James Bostwick, a San Francisco plaintiff's lawyer outlined five tac-

tics for coping with PCEs:[178]

(1) Communication. "Do not stop talking to the patient. You need

to communicate more at this time. If people like you, 90 percent of the

time they will not sue. If they are going to sue anyway, you have not

hurt yourself by communicating with them."

(2) Investigation. Investigate the incident from a positive stand-

point. Use a "we want to see what we can do to help" attitude. For

the employees, stress that the investigation will help to see what

action to take to make their jobs easier.

(3) Legal representation. Do not leave the matter in the hands

of a defense lawyer who is acting on behalf of the insurer. Find out

what is going on with the case. The hospital might need its own law-

yer to look into the situation. Further, a defense lawyer who is being

paid by the insurance company may not be acting in the best interest

of the hospital. Insurance officials may want to settle out of court

to avoid high legal fees and publicity, regardless of liability. The

reputation of the hospital must be considered in defense alternatives.

(4) Staff assignment. Hazard zones for potential malpractice

claims include the operating room, the emergency room, and anesthesia

services. These areas, because of their potential for litigation,

should be staffed with extremely efficient and professional employees.
The physician who cannot practice anywhere else should not be working
in the emergency room.

(5) Medical staff insurance. Make sure that the physician is
insured. Lawyers will sue where the money is. They will find a way
to hold a hospital liable in a lawsuit if the physician is not insured.[179]
One case involving an Rh-Factor infant who developed jaundice illustrates
this point. Although the nurses attending the baby charted carefully
the jaundice and their efforts to get the uninsured attending physician
to take action, the hospital was found liable. Because the nurses did
not report the matter to a supervisor or someone higher up in the ad-
ministration, who had the authority to get the physician to act or to
remove him from the case, the hospital paid. This suit against the
hospital would not have been necessary if the physician had been in-
sured.[180]

For detailed studies regarding occurrence screening and handling
of PCEs, see Appendix H .

Success of Individual Risk Management Programs

Since the late 1960s, Lovelace Medical Center in Albuquerque, New
Mexico has operated a risk control program to improve its quality of
health care and minimize its liability to malpractice claims. The im-
petus for the program came, in part, from a malpractice suit filed against
the medical facility approximately 15 years ago. The outcome of the
suit was a large financial assessment against the facility that could
only partially be paid by the insurance. As a result of this problem,
the staff sensitivity to malpractice risk, and the administration's
support for the risk control program, a strong program was

developed.[181]

The risk control program at Lovelace Medical Center covers all its divisions and special services. These include a clinic division, a multi-specialty group practice of 80 physicians, a 200-bed hospital which contains an 18-bed alcohol treatment rehabilitation unit, a 100-bed extended care facility, a satellite family practice clinic in the greater metropolitan area, and a health maintenance organization that serves 5,000 persons.[182]

The organization and functioning of the risk control program are standard throughout the medical center. The activities of the risk control program are initiated through incident reports which, if they denote a serious or legally threatening situation, are singled out by the risk control manager for discussion and for the preparation of a legal defense by the professional review committee.[183]

Lovelace Medical Center defines the incident as any happening, with or without injury, involving patient mishap or serious expression of dissatisfaction. An expression of dissatisfaction by the patient is a result of the patient perceiving, rightly or wrongly, that he or she has, in some manner, been slighted, neglected, mistreated or injured. Types and examples of incidents, according to the risk manager at the medical center, are as follows:

(1) Sudden unexpected death or injury secondary to diagnostic or therapeutic procedures (e.g., x-ray burn, pressure sores from casts);

(2) Drug error, reaction or injury;

(3) Fall, for any reason and with or without harm;

(4) Mishap due to faulty equipment or environment (e.g., broken wheelchair, loose railing, unmarked steps);

(5) Expression of dissatisfaction of the medical care provided
or with the bill received;

(6) Serious complaint about delays;

(7) Hint of legal action; and

(8) Unexplained requests from an attorney for information about
a patient.

All health care personnel should learn to recognize incidents
and respond to them quickly and Lovelace Medical Center educates its
employees to enable them to do that.[184]

Management and analysis of incident reports is the responsibility
of the risk control manager at Lovelace Medical Center. The Professional
Review Committee includes the risk manager, the director of nursing, and
six members of the medical staff who were selected by the chief execu-
tive officer in consultation with the chairman of the medical staff.[185]

Since 1971, 28 suits have been filed against the medical center.
Two cases were settled out of court, seven were won and nine are pending.
Claims paid have been only a small percentage of the center's insurance
premiums. Consequently, the program has been a success, according to
spokesmen for the medical center.[186]

In early 1977, Methodist Medical Center of Illinois, a 526-bed
acute care teaching facility in Peoria, initiated a self-insurance
program for professional liability coverage. To facilitate the develop-
ment of this program, a risk management committee was formed in 1976
to investigate the means by which the hospital's risk as both the
insurer and the insured institution could be diminished.

Prior to the implementation of the medical center's quality
assurance program, quality-oriented or safety-related issues had been

under the purview of two separate groups--(1) those concerned with environmental safety, and (2) those involved in medical staff peer review. The environmental safety group was headed by the safety director and was involved with safety and disaster programs, third party inspection reports, in-service training for nurses regarding equipment safety, and incident reporting.[187] The medical staff group was primary composed of independent peer review committees, such as audit and utilization review, tissue review, medical records, infection control, credentials and continuing medical education.[188]

The major problem with the environmental safety group was that its focus was reactive rather than preventive.

The main drawback to the activities of the medical staff group was that the lines of responsibility were not clear in the routine situations, and less clear in the non-routine cases. The inevitable result was that there was no formal resolution of the problem.[189]

To achieve the hospital's commitment to an effective patient safety program and liability control system, a multi-disciplinary approach was needed. The executive vice-president then formed a risk management committee composed of physicians, nurses and other hospital personnel. Most committee members, who were chosen on the basis of their creative problem-solving skills, represented units and departments having high liability potential (e.g., the operating room, the emergency department, laboratory and the maintenance department). The risk management committee reviewed the ways in which the medical center was affected by the nation-wide insurance crunch of the 1970s and the potential ramifications of the hospital's decision to self-insure. The committee then produced five recommendations believed to

be necessary for the success of the risk control program at the
medical center. These recommendations are as follows:

(1) Policies and procedures should be examined to ensure and
facilitate patient care with a minimum of inconvenience to patients;

(2)Qualified personnel should be hired and retained to ensure
that patients receive high quality care;

(3) Provider/patient relationships should be examined to identify
and correct situations in which patient dissatisfaction might result
from patient interraction with hospital staff members;

(4) Education programs for physicians, nurses and other hospital
personnel should be provided to promote understanding of the importance
of minimizing the hospital's liability; and

(5) Claims review should be streamlined and data collection im-
proved.[190]

As a result of this risk management program, the medical center
realized improvements in patient safety and quality of care. Centralized
control of safety and quality-related activities introduced a method of
supervision for the program. Communication among committees was strength-
ened and accountability was defined through the functions of the Quality
Assurance Committee and the vice president of medical affairs. During
the past year, the Quality Assurance Committee has addressed and resolved
numerous issues.[191]

The Risk Management Committee. A risk reduction program must have
an organizational unit charged with analyzing information related to
potential risk to patients and with ensuring that appropriate action
is taken when necessary. While it is possible that the administrative
program manager, coordinating as much as possible with other individuals,

can perform this role, the use of one or more committees is considered
to be a superior approach. The committee structure offers a forum for
the discussion of liability and safety issues drawing upon the exper-
tise of a wide range of disciplines and organizational units, both in-
ternal and external to the hospital.

According to Nancy Dumas, patient representative at the 220-bed
Griffin-Spaulding Hospital in Griffin, Georgia, hospitals do not have
to have a person entitled risk manager to effectively monitor potential
problems and implement corrective measures. Dumas' hospital uses a
committee to handle the risk management activities. This committee
approach, Dumas maintains, is perfect for the smaller institutions which
are unable to justify financially the creation of a salaried risk manager
position.[192]

In addition to the financial savings that result from the com-
mittee approach, there is the added benefit of hospital-wide coopera-
tion on risk management. Those serving on the "Patient and Public Safety"
(risk management) Committee include a social worker, the business
office manager, a nursing supervisor, a utilization review nurse,
a patient representative, the chief pharmacist, and the chief of
radiology.[193]

Using the Patient and Public Safety Committee as a risk manage-
ment coordinating group was a natural outgrowth of the hospital structure.
The hospital wanted to use a committee that it already had rather than
to form a new one.[194] Having the committee as an active "core" group
for risk management functions was seen as an essential element of the
program, because a number of other committees with "fringe" risk manage-
ment duties already looked to the Patient and Public Safety Committee

for leadership.

The Patient and Public Safety Committee has sub-groups such as employee safety, disaster, environmental control and fire safety groups, which also deal with individual segments of the risk management program. These smaller groups handle only the specialized duties outlined in their titles and look to the Patient and Public Safety Committee for overall risk management direction.[195]

The committee reviews all the incident reports, patient Representative's reports, and nursing services documentation. Then the committee makes recommendations on communications to be directed to the patient and the patient's family. Also, recommendations on in-service training and staff education in relation to the problem can be made by the committee.

Another responsibility of the committee concerns follow-up of incidents. If there is a patient fall or a medication error, the committee decides what course of action is best to take. Only when the committee members are unable to agree on what course of action to be taken, is intervention from the assistant administrator necessary. To date, the committee has not had to call on him for help in making decisions.[196]

Evaluation. Fragmentation and duplication of efforts, not knowing if problems that arise are transitory or chronic, and the perenial question of whether review activities are worth the cost, were issues plaguing the administration and medical staff at a community hospital. The hospital hired its first quality assurance director, a registered nurse with a master's degree in hospital administration. The hospital, a 600-bed acute care facility, has long been an active participant in quality

assurance activities.

The hospital used a quality assurance/risk management (QA/RM) Management Profile Analysis to analyze the hospital's existing quality assurance and risk management functions, committees, personnel, and reporting lines.[197]

Using the QA/RM Management Profile Analysis, the quality assurance director and the quality assurance consultant set out to determine who was collecting data and identifying problems, where the information was being reported, and whether such information was being used to solve problems.

Designed to help hospital personnel identify the extent of problems and the scope of the hospital's risk management activities as necessary prerequisites to establishing an integrated quality assurance/risk management program, this tool provided a way for the hospital to profile, or identify, its existing functions, committees, personnel, and reporting lines, for analysis.[198]

Each quality assurance activity was reviewed and the following information was obtained:

(1) To whom results of the activity are reported;

(2) The location of the minutes and/or reports filed for the activity;

(3) The primary data sources;

(4) The title (or name) and department of quality assurance support personnel who assist the committee or activity in its functions; and

(5) The title (or name) and department of clerical support personnel who are responsible for scheduling meetings and for taking and typing minutes.[199]

The QA/RM Management Profile Analysis indicated that the hospital's risk management committee was inadvertently a burial ground. It was receiving reports from the safety officer and summaries of incident reports prepared by the secretary to the hospital administrator, but it did not review data related to clinical problems detected by the other committees, nor did the risk management committee report to the executive committee, or to any other committee.[200] Additionally, problems discovered in interviews with hospital personnel and in reviews of continuing education programs were reported only to the associate administrator for employee relations, and not to the risk management committee.[201]

The type of reporting described above was clearly diluting the hospital's risk management program. Committee members felt that they were simply filling paper requirements and they seldom knew whether a problem was ever resolved.[202]

The Quality Assurance/Risk Management (QA/RM) Management Profile Analysis can be invaluable in helping administrative personnel, medical staffs and quality assurance personnel focus their efforts on centralizing information collection. Analysis found that the quality assurance and risk management activities in many hospitals have grown into paper-work monsters. Many facilities and risk management activities have been added without being integrated into existing functions. Important information that would make all activities more effective is being lost or underutilized, and both professional and support time is being used inefficiently.[203]

Problem Solving Methodology

In order to develop a comprehensive risk management program at the USAF Academy Hospital, it was determined that a systems approach would be utilized. First, as has already been discussed, the magnitude of the problem had to be determined. This was accomplished through a systematic and thorough review of historical data and case files, interviews with hospital personnel and their legal advisors and an in-depth review of the military literature on the subject.

The second major step in the problem-solving methodology was to review all available literature on the malpractice problem and risk management in order to: (1) determine the magnitude of the problem in civilian hospitals, and (2) discover how those hospitals resolved their risk management and malpractice problems.

Finally, a seven-phase, systematic approach was employed in developing and implementing a comprehensive risk management program at the USAF Academy Hospital, utilizing the best information gleaned from literature, interviews, seminars and discussions on the subject. This seven-phase approach to development and implementation of the program at the Hospital will be discussed in the next chapter.

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II. DISCUSSION

A Systems Approach

"We are shifting rapidly from a Cartesian view of the uni-
verse in which the accent has been on parts and elements,
to a configuration view, with the emphasis on wholes."

- Peter Drucker

The Systems approach was utilized to develop a comprehensive risk
management program at the USAF Academy Hospital. The systems approach
provided an organized methodology for planning, organizing and con-
trolling the various phases of the project.[1] This approach, among
its other benefits, allowed for a thorough, systematic methodology for
planning, analysis, data collection and evaluation, review, implementa-
tion and follow-up. Additionally, the systems approach enabled the
project officer to more fully understand and work within the parameters
of the numerous hospital functional departments which have interrelated
and, sometimes, overlapping responsibilities for risk management and
which must operate in concert to achieve optimal program results.

Other hospitals have utilized the systems approach effectively in
developing risk management programs. The editors of Quality Review Bulletin
state that the systems approach to risk management brings together the
hospital's existing programs of quality assurance and liability control
into a single, unified system of risk detection, evaluation and
prevention.[2] Donc'an and Bader state that the systems approach applied
to risk management is not an organizational chart of inputs, outputs,
processes and controls, as General Systems Theory espouses, but rather
a system of people working together to attain the goal of optimal treatment

of patients under their control[3]

According to the American Hospital Association (AHA), hospitals can develop the best risk management program by applying a systems approach[4] The AHA states that the systems approach to controlling hospital liability has several advantages:

(1) The systems approach brings together key people who deal with liability in various ways: physicians, nurses, administrative staff, department heads, safety committee members, legal counsel, other hospital staff, and insurance carrier staff.

(2) The systems approach brings together elements of the quality assurance and risk management programs that currently operate separately from each other: medical audit, nursing audit, incident reports, safety committee, training and education, and product review.

(3) The systems approach assigns specific accountability for results. Accountability might be held by the administrator, the medical director, the liability control (risk management) committee(s), a special task force, or a board committee.

(4) The systems approach establishes formal and regular lines of communication, enables prompt action, establishes channels of communication where none previously existed, and encourages cooperation under a management mandate.

The systems approach to risk management is based on the premise that the hospital already possesses information critical to averting claims or reducing their financial severity.[5] Incident reports, medical records, past claims against the hospital, and proceedings of the medical audit, tissue and infections committees, for example, form the

basis for a large and, for the most part, un-tapped information base.

Currently, most of this information lies in file drawers and the memories of hospital personnel until a claim is filed against the hospital. [6] The systems approach enables the hospital to "get its act together" prior to a claim being filed. Consequently, the hospital is able to sort through the voluminous amounts of information scattered throughout the hospital, consolidate relevant information, identify potential claims against the hospital and take immediate corrective and/or remedial action.

Figure 2, adopted from Lanier and Brown, [7] describes the methodology by which the development of the comprehensive risk management program at the USAF Academy Hospital was undertaken. Each of the phases of the risk management program development at the hospital will be discussed.

PHASE I - PROJECT INITIATION PHASE

Although the staff at the USAF Academy Hospital realized the need for a risk management program and, in fact, already had many of the aspects of a risk management program (e.g., quality review, safety program, patient advocacy program, incident reports, etc.) the direction and impetus for establishment of a formalized hospital-wide risk management program came from Headquarters, U.S. Air Force. At the 1979 USAF Command Surgeon's Conference, held on 13 June 1979, Lieutenant General Paul W. Myers, Surgeon General, USAF, directed that a program of Risk Management (malpractice claims prevention) be devised, and a plan for implementation be prepared by 1 October 1979. [8] A proposed model, based upon the civilian experience, was presented to the conference

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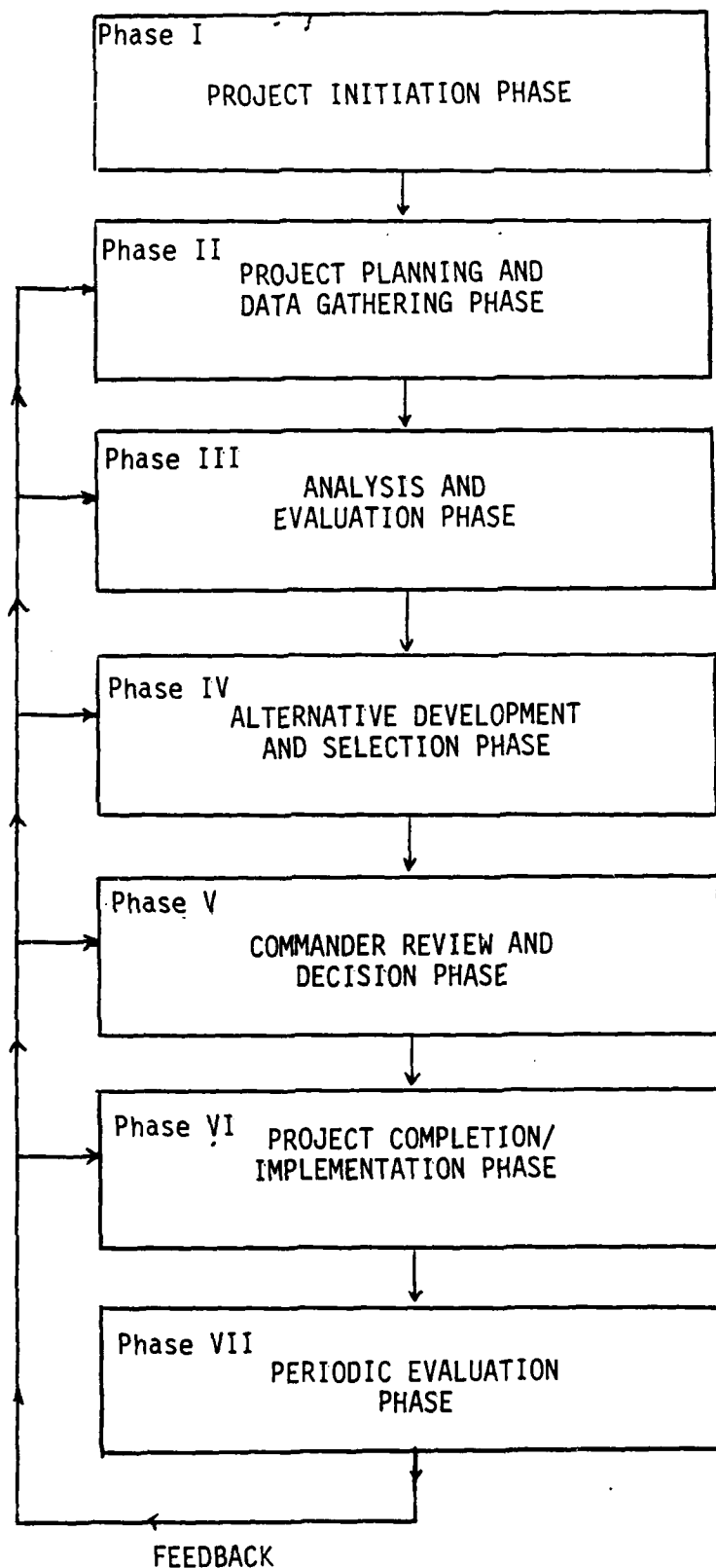
FEEDBACK

Figure 2: Problem-Solving Methodology: A Systems Approach. Adapted from Colonel Jack O. Lanier, and Major Roger L. Brown, U.S. Army, MSC, "A Systems Approach to Restructuring a Health Care Curriculum," U.S. Army-Baylor University Bulletin of Continuing Graduate Education, Fall and Winter 1978, p. 9.

by Major Walter D. Phillips, HQ USAF/JACC. This model (see Appendix I),
provided the starting point for the Air Force program in risk manage-
ment.[9]

To gain input from the pertinent Air Force functions, in formulating
the Air Force risk management program, a two-day workshop was conducted
at Brooks AFB, Texas, on 17-18 July 1979. Colonel George A. Kaye,
Administrator, USAF Academy Hospital, attended this workshop, and obtained
information which would prove invaluable as the USAF Academy Hospital's
own risk management program was being developed.

A short course for USAF Hospital Risk Managers was conducted at
Sheppard Air Force Base, Texas, during November and December 1979.
Major Val J. Bateman, USAF Academy Hospital Associate Administrator,
and appointed Risk Manager, attended this course and brought back
information to be utilized in developing a risk management program
at the Hospital.

In December 1979, Captain Charles W. Boone, Administrative Resident
at the Hospital, proposed development and implementation of the risk
management program for his Problem Solving Project (PSP). Also in
December 1979, the development and implementation of the risk management
program as a PSP was approved by the faculty of the U.S. Army-Baylor
University Graduate Program in Health Care Administration. Immediately
thereafter, Captain Boone began an extensive review of the military
and civilian literature on risk management.

In January 1980, the draft Air Force Regulation 168-X,"Medical
Administration: Risk Management in Medical Care Delivery," 1 January
1980, was distributed (see Appendix J). This draft regulation was to

provide interim guidance for Air Force hospitals in establishing risk

management programs, pending its official publication.[10]

In February 1980, a letter from HQ USAF/SG directed that individual

hospitals implement risk management programs immediately (see Appendix K).

This letter also provided broad guidance on implementation of risk

management programs. By this time, the second phase of the risk manage-

ment project at the USAF Academy Hospital had begun.

PHASE II - PROJECT PLANNING AND DATA GATHERING PHASE

In January 1980, planning for development of a comprehensive risk

management program was begun that would incorporate the best aspects of

the existing risk management-type activities and fully integrate all of

the Hospital's risk management functions, while meeting the criteria

and limitations discussed earlier.

Review of civilian health care literature regarding risk management

had become an ongoing task for the risk manager and the Administrative

Resident. Approximately 200 health care journal articles were reviewed

which provided information regarding the malpractice problems, the

development and implementation of risk management programs in military

and civilian hospitals and strengths and weaknesses of individual

hospital's risk management programs.

The Hospital risk manager and the administrative resident, both

members of the American Society for Hospital Risk Managers, attended

a risk management seminar sponsored by that society in New Orleans,

during the period 16-18 March 1980. At this seminar, these individuals

attended in-depth lectures by physicians, lawyers, risk managers,

insurance representatives, nurses and other medico-legal personnel,

and conducted interviews with, and interacted with, risk managers and other personnel engaged in risk management activities in both military and civilian hospitals.

It was discovered from all of the data gathering methodologies that there are certain elements which are essential to effective risk management programs in hospitals. The first element which was found to be common to nearly all successful risk management programs was that there was almost always a single individual designated "risk manager" (or a similar title), who served as the focal point for accumulation and dissemination of risk management information and who coordinated the various risk management activities throughout the hospital.

A second element common to effective risk management programs was that a multi-disciplinary committee had been organized to coordinate risk management activities in the hospital, identify problem areas, to conduct educational programs for hospital personnel regarding risk management and to either take corrective measures or to recommend to top management corrective measures to be taken. This committee, usually referred to as the Risk Management Committee, normally included the risk manager, at least one physician representative, at least one nurse representative, a representative from the hospital's safety office and a legal representative. Other members could be appointed as necessary.

A third major element which was found in the most successful risk management programs was the full support of the program by the Chief Executive Officer. The interest of top management in Air Force risk management programs was demonstrated by HQ USAF/SG directing establish-

ment of a risk management program, Air Force-wide, during the 1979

Command Surgeons Conference and again in a personal letter to medical

treatment facility commanders for immediate implementation of risk

management programs at each facility. The support of the USAF Academy

Hospital Commander was evidenced by his allocating resources for

educating key risk management personnel on a TDY basis and by his

personal involvement as an ex-officio member of the Hospital's Risk

Management Committee.

A fourth element which was common to effective risk management

programs was the participation in the program by the medical staff.

Corbett emphasized participation of the medical staff. He states:

> "A hospital's medical staff must play the major role
> in reducing injuries and subsequent malpractice
> claims." [11]

Fifer sees risk management as the art of preventing people failure.

He states that doctors are people. Once one accepts that premise what

follows is that doctors will make mistakes. More than most people,

doctors who are members of an organized hospital medical staff are in an

especially good position to predict when a mistake is likely to occur

and to take steps to prevent it from happening. As members of the

organized medical staff they have a collective responsibility for

establishing standards of clinical care, for continually reviewing and

evaluating the quality of care they provide against those standards,

and for taking appropriate action when substandard care is discovered.

Incidents are more often the result of people failures than equipment

failures; a well-trained and highly motivated staff is a hospital's

best resource for reducing the potential for patient injury. [12]

Effective systems of communication within the hospital and good patient/provider relations are two other elements essential to effective risk management programs in hospitals.

Consistently in the literature these six elements were listed as key ingredients to successful risk management programs. Obviously, there are other key factors essential to the effectiveness of risk management programs. Ashby, et al, identified 14 necessary elements, of which only six were considered most important.[13]

The AHA identified eight steps to establishing a risk management program in hospitals:

(1) Obtain top-level commitment,

(2) Integrate training and educational programs,

(3) Identify high-risk priorities,

(4) Establish and refine policies, procedures and documentation,

(5) Choose and implement an organizational model,

(6) Improve physician-patient-nurse-hospital communications,

(7) Improve post-claims coordination, and

(8) Evaluate the system.[14]

For a detailed guideline to implementing a risk management program utilizing the systems approach, see Appendix E.

The risk management program to be established at the USAF Academy Hospital should incorporate the best elements and means identified with effective risk management programs through the country.

PHASE III - ANALYSIS AND EVALUATION PHASE

Analysis and evaluation of the Hospital's existing risk management-type activities was accomplished in order to:

(1) Assess the extent of risk management-type activities already in effect at the Hospital,

(2) Identify structure, function and interrelationships between committees and programs having risk management-type responsibilities at the Hospital,

(3) Determine if deficiencies existed in the facility or its programs,

(4) Determine if trends existed which were conducive to having claims filed against the government, and

(5) Assess the specific needs of the Hospital so that a comprehensive risk management program could be developed to meet those needs while complying with the provisions of Air Force Regulation 168-X, "Medical Administration: Risk Management in Health Care."

A comprehensive analysis of the Hospital's committee structure and functioning was accomplished with particular emphasis upon the following committees:

Credentials Committee

Emergency Service Review Committee

Infections Committee

Medical Care Evaluation Committee

Medical Records Committee

Medical Services Committee

Nursing Care Evaluation Committee

> Nursing Services Professional Procedures Committee
>
> Patient Education Committee
>
> Professional Staff Meetings
>
> Radiation Safety Committee
>
> Safety Committee
>
> Surgical Staff Meetings
>
> Special Care Unit Committee, and the
>
> Tissue Committee

The Quality Assurance/Risk Management (QA/RM) Management Profile Analysis, developed by Stearns and Fox,[15] was utilized to review committee structure and functioning and to assess the USAF Academy Hospital's existing risk management-type activities. Designed to assist hospital personnel in identifying the extent of problems and the scope of the hospital's quality assurance and risk management activities, the QA/RM Management Profile Analysis provides a methodology by which to profile, or delineate, existing functions, committees, personnel, and reporting lines.[16]

Each activity and/or committee required by the hospital was listed in the profile. Then each quality assurance/risk management activity was reviewed to determine the following information:

(1) To whom results of the activity were reported. When results were being reported to more than one person or group, every person or group was recorded on the profile analysis.

(2) The location of the minutes and/or reports filed for the activity. Although the minutes of committee meetings were being distributed to more than one person(committee members) and to the executive committee, the location of the master (or file) copy was of primary

interest for the purpose of this analysis. A corolary here was "who was responsible for confidentiality?"

(3) Primary data sources (e.g., medical records, incident reports).

(4) The title and department of QA/RM personnel who provided assistance to the committee or activity in its RM function, and

(5) The title and department of clerical support personnel responsible for scheduling meetings and taking and typing minutes.[17]

The purpose of accomplishing the QA/RM Management Profile Analysis was to evaluate existing hospital programs to determine if:

(1) An overlapping of responsibilities and services existed,

(2) Clear lines of reporting, authority and accountability for committees and support personnel were lacking, and

(3) Potential confidentiality problems existed.[18]

Review of committee structure and functions at the USAF Academy Hospital, utilizing the QA/RM Management Profile Analysis, revealed that while numerous risk management-type activities were being accomplished within individual committees, there was little cross-feed of information between committees on risk management matters with two exceptions: (1) where certain active committee members served on more than one committee with quality assurance or risk management functions, cross-feed occurred, and (2) the hospital executive committee reviewed the minutes of all other committees. Therefore, discrepancies and/or duplication of effort, etc., with regard to risk management could be identified and resolved.

Some duplication of effort was evidenced because of lack of cross-feed of information, but this was minimal.

Analysis of the hospital's patient advocacy, incident reporting

and patient questionnaire procedures was accomplished. Additionally,
a review of historical data was accomplished. Further, a review of
inspection procedures of the physical plant for safety hazards was
accomplished. The last survey report by the Joint Commission on
Accreditation of Hospitals (JCAH) and the inspection report of the
most recent Health Services Management Inspection (HSMI) were reviewed.
The purpose of these reviews was to ascertain whether or not deficien-
cies existed, either in the physical plant or in the professional
practice at the hospital, which could lead to liability claims against
the government.

An analysis of all malpractice claims against the government
which named the USAF Academy Hospital as the causal agent or a con-
tributing agent was performed in order to identify trends that existed
which could be curtailed. Historical analysis of such claims revealed
that the hospital had been named in eight claims, totalling $12 million
during Fiscal Years 1978 and 1979.[19] Of the eight claims filed, no
definitive trend could be identified in terms of type of negligence
or cause.

One case claimed wrongful death (a cadet with ulcerative colitis
had been treated extensively at the USAF Academy Hospital and was
returned to his squadron.) Shortly thereafter, the cadet died.

One claim resulted from a hernia repair operation which the Plaintiff
alleged resulted in his becoming sexually sterile, a condition which
the patient did not relish. Recent medical evidence indicates almost
conclusively that the hernia repair and the patient's sexual sterilization
were unrelated.

One claim relating to the circumcision of a child was settled out of

court.

One female patient presented with multiple complaints and was given a myelogram in response to a complaint of low back pain. Dye injected into the patient's back could not be removed and the patient filed suit for that and other problems.

One claim resulted from a patient with a broken leg (which was sustained in an automobile accident). The hospital re-set the leg with cast and the bone "grew back wrong," leaving a gap between the two portions of the bone between which the break had occurred.

Another claim was filed by an Air Force officer who had had his knees operated on at the USAF Academy Hospital when he was a cadet. A physician at the USAF Hospital, Vandenberg Air Force Base, California subsequently told the officer that the USAF Academy Hospital's surgeons had "messed up his knees."

Another claim alleged that the hospital had been negligent in repairing a laceration to the thumb. According to the claim, a severed tendon and nerve in the patient's hand went untreated.

Finally, a settlement payment of $750,000 was made by the Air Force to a 19-year old diabetic male who lapsed into a coma following a number of visits to the USAF Academy Hospital. The patient was suffering from acidosis, an abnormal increase in the acidic level of the blood, resulting in carbon dioxide retention. Medical personnel at the hospital failed to conduct blood gas and serum acetone tests, even with the knowledge of the patient's diabetic condition, and, instead, treated him for a routinely-encountered viral infection. As a result of the diabetic coma, the patient suffered three cardiac arrests and is now paralyzed from the waist, down, is blind in the

left eye, and is without normal bladder function.[20]

Results of the Analysis and Evaluation Phase revealed that there were several areas in the Hospital which could be improved if a comprehensive risk management program was implemented. A single committee, to serve as a sort of a "linking pin," which could coordinate and channel communications relative to risk management, would vastly improve the Hospital's overall risk management program.

PHASE IV - ALTERNATIVE DEVELOPMENT AND SELECTION PHASE

For the purpose of this problem-solving project, the alternatives to developing a risk management program have been limited, yet plentiful. The pre-established criteria and limitations eliminated many alternatives which were gleaned from the literature review and from analysis of the problem. Implementation of some of the alternatives were not within the authority of the Commander, USAF Academy Hospital. Other alternatives, such as purchase of commercial liability insurance, were not only infeasible, but also impractical, since for malpractice accomplished at the USAF Academy Hospital, it is not the Hospital that must pay, but the U.S. Government.

In addition to the constraints named above, Headquarters, USAF provided certain constraints and guidance which had to be complied with in development of a risk management program.[21] Further, external (e.g., political) factors enfluenced the type of program that the USAF Academy Hospital could develop. The Hospital is highly visible as the Academy is a sort of a "showcase" for the Air Force. In addition to over 1 million tourists visiting the Academy annually, many of the cadets who attend the Academy do so by Congressional

appointment. Consequently, the cadets feel that they can contact
their congressmen, and do, when medical complications develop.

Because of the rather restrictive nature of the USAF and USAF
Academy Hospital regulations, policies and procedures, and yet,
the almost endless opportunities to incorporate specific elements
and local procedures into the program, it was determined that a
risk management program would be developed that would best suit
the needs of the Hospital, while meeting pre-established criteria
and not exceeding pre-established limitations. Simultaneously,
the program would incorporate the best aspects of risk management
programs developed in the civilian health care sector.

It was determined that the optimal feasible solution to the
problem would be a comprehensive risk management program which would
meet the requirements described above. The program had to meet all
of the criteria, limitations and "best element" features which were
discussed in Chapter I. Figure 3 demonstrates that the program
selected meets all of the criteria identified as necessary for the
risk management program to be developed at the USAF Academy Hospital.
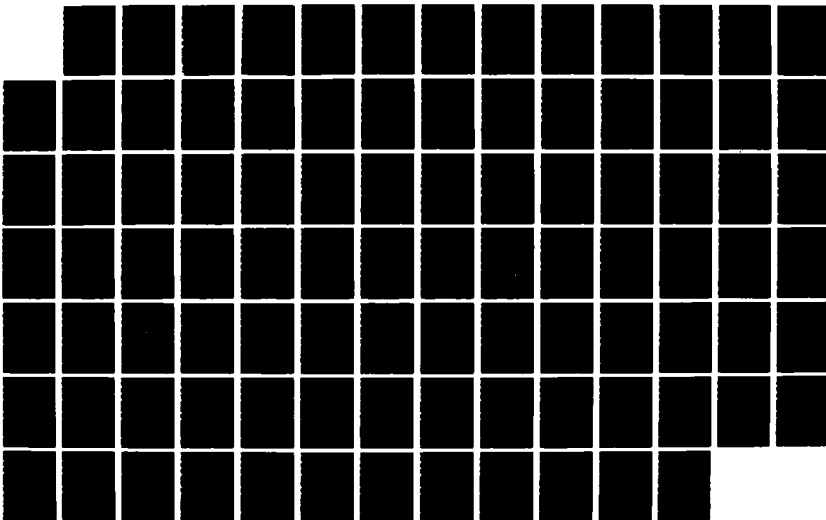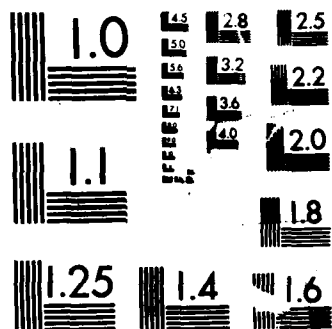
AD-A187 344   DEVELOPMENT AND IMPLEMENTATION OF A COMPREHENSIVE RISK   2/2
MANAGEMENT PROGRAM AT THE USAF ACADEMY HOSPITAL(U) ARMY
HEALTH CARE STUDIES AND CLINICAL INVESTIGATION ACTIVITY

UNCLASSIFIED F   C W BOONE APR 80   F/G 6/5   NL

MICROCOPY RESOLUTION TEST CHART

NATIONAL BUREAU OF STANDARDS-1963-A

CRITERIA Best Elements	CRITERIA MET?	
	Yes	No
1. Support of Chief Executive Officer?	X	
2. Support of the Medical Staff?	X	
3. Involvement of Patient Advocate?	X	
4. Active Involvement of Nursing Staff?	X	
5. Individual Designated "Risk Manager?"	X	
6. Risk Management Committee Established?	X	
7. Ongoing Education Program for all Hospital People?	X	
8. Uses Incident Reporting System?	X	
9. Utilizes the Systems Approach?	X	
10. A Comprehensive Program?	X	
Project Criteria	10	0
11. Program Implementation within Authority of Hospital Commander?	X	
12. Program Meets Needs of USAF Academy Hospital?	X	
13. Program Acceptable to Hospital Management and Providers?	X	
14. Cost of Program does NOT Exceed Expected Benefit?	X	
15. Program Meets HQ USAF Criteria?	X	
Project Limitations	5	0
16. Implementation of Program Made Within Existing Budgetary Constraints?	X	
17. Implementation of Program Made with NO Increase in Manpower?	X	
18. Implementation of Program Accomplished NLT April 25, 1980?	X	
	3	0
	18	0

Figure 3: Evaluation of Program against Criteria.

PHASE V - COMMANDER REVIEW AND DECISION PHASE

After selection of the optimal feasible solution, regarding the type of program to implement, the proposal was presented to the Commander, USAF Academy Hospital for review and approval. Implementation of the proposed program was within his authority.

The Commander accepted the proposal and directed that immediate steps be taken to fully develop and implement the program at the Hospital.

PHASE VI - PROJECT COMPLETION/IMPLEMENTATION PHASE

As the project to develop a comprehensive risk management program at the USAF Academy Hospital had been completed, immediate steps to implement the program were necessary. Having already appointed a risk manager (and the administrative resident to develop a program), a solid foundation for the implementation phase had been formed.

Incorporation and integration of all of the necessary elements of the program would be a major and ongoing task.

Risk Management Committee

A multi-disciplinary risk management committee was established (See Appendix L) to steer implementation of the risk management program at the hospital and to serve as decision-makers (on behalf of the Hospital Commander) for positive problem resolution within the facility.[22]

The committee consisted of the:

(1) Hospital Commander (ex-officio member);

(2) Chief, Hospital Services (Chairman);

(3) Hospital Administrator;

(4) Chief, Nursing Services;

(5) Associate Administrator (Risk Manager);

(6) Plant Manager (Safety Committee Representative); and

(7) Legal Advisor.

In accordance with Air Force Regulation 168-X, the Risk Management Committee must meet at least quarterly. The USAF Academy Hospital determined that its committee would meet monthly in order to form a firm program foundation, to educate committee members, and to, in short, bring all of the risk management-type activities being accomplished in the hospital under the auspices of the committee.

The committee is responsible for ensuring that appropriate quality assurance components exist and function effectively for the Hospital. The committee maintains close liaison with the Credentials Committee and may make recommendations to it.

The scope of review of the committee is left to the discretion of the Hospital Commander, but routinely includes:

(1) Review of all items presented by the risk manager or other committee members. In taking corrective action, the committee assures that facility monitoring efforts, including medical audits, are directed toward priority and/or identified problem areas. In this regard, the committee assures that the criteria used in medical audits are clinically valid.

(2) Support of the risk manager in education/training of hospital personnel. In addition, the risk management committee directs continuing medical education to priority and/or identified problem areas.

(3) Review of minutes of other committees within the hospital for items involving risk management. In this regard, the committee will assure that all other hospital committees are aware of the risk management program and the responsibility to communicate appropriate items to the risk manager or the risk management committee.

(4) Referral of problems to HQ USAF when the solution is partially or wholly beyond the scope of the committee.

(5) Follow-up on corrective/remedial actions recommended by the committee. Effective management of the program requires that the remedial action be monitored to assure that the desired result has been attained. This may include special reports back to the committee from other hospital committees or functions.

To date, the Risk Management Committee has met three (3) times. The committee has identified problems and acted to resolve these problems. The committee directed that a major program to educate all hospital personnel on risk management be initiated. Minutes of all three meetings are provided at Appendix M .

Risk Management Education Programs

Captain Martin, the legal advisor to the Risk Management Committee, attended a Hospital Law Seminar in April to better equip him to deal with Hospital risk management matters. The Risk Management Committee will be briefed on the most recent medico-legal issues at its next meeting.

In March, Major Bateman, the risk manager and Captain Boone, the program development project officer, attended a three-day risk management educational program in New Orleans, to learn more about risk

management through attendance at seminars and interviewing and
interracting with risk management experts from throughout the
country. Upon returning from the seminar, the two of them began
a program in the Hospital to educate:

(1) The Risk Management Committee;

(2) The Professional Staff;

(3) The Nursing Staff;

(4) Other Personnel Involved with Direct Patient Care; and

(5) All other Hospital Personnel.

To date, the Risk Management Committee, the professional staff
and nearly half of the nursing services staff have been briefed on
the Hospital Risk Management Program and their responsibilities
with regard to the program. This educational process will con-
tinue until all hospital personnel have been briefed. Periodic
sessions will be provided in order to educate newly-assigned per-
sonnel shortly after their arrival and to provide ongoing reinforce-
ment to all personnel.

Patient Questionaires

Patient questionaires are an integral part of the patient relations
portion of the risk management program at the USAF Academy Hospital.
Specific information regarding the use of patient questionaires is
provided in Hospital Regulation 168-1 (See Appendix N).

Inpatient and Outpatient Questionaires used in conjunction with
the program are provided at Appendix O .

Incident Reporting

Consistent and timely reporting of incidents is essential to

effective risk management. Incidents include any happening or result not consistent with routine hospital operation or the routine care of patients. Any event which can lead to a claim against the government will definitely be reported. The Air Force Form 765, Hospital Incident Statement, will be utilized to report such incidents (See Appendix P). Information recorded on the form should be factual, avoiding opinions or conclusions. The completed form will be routed to the hospital risk manager without delay. The statement will not be filed with, or referred to, in the medical records.

In addition to the written incident report, providers and other hospital personnel have been encouraged to contact the risk manager immediately, either by phone or in person, when a situation arises which could lead to a claim against the government.

Hospital Regulation

The final implementation action to be accomplished is publication of a USAF Academy Hospital Regulation to set up formal guidelines and fix specific responsibilities for the risk management program at the Hospital. A draft of such a regulation is being coordinated through the various hospital departments now. Publication of the regulation is expected in early May 1980. A copy of the draft regulation is provided at Appendix Q . This regulation sets forth the most important features of the risk management program developed at the USAF Academy Hospital.

PHASE VII-PERIODIC EVALUATION PHASE

The Risk Management Committee will analyze the operation of the

risk management program at the Hospital at least annually in order
to determine if the scope, structure and priorities which have been
established for the Hospital are appropriate. If evaluation of the
overall program, or of any part of the program, is deemed inadequate,
the committee will take corrective action to immediately upgrade the
deficiencies.

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III. CONCLUSION

Critical analysis of all aspects of the malpractice problem at
the USAF Academy Hospital, a thorough review of health care litera-
ture regarding risk management in the civilian sector, and a HQ USAF-
recognized need for risk management in Air Force hospitals, established
the need for development of a comprehensive risk management program
at the USAF Academy Hospital.

A systems approach was utilized in the development and implementa-
tion of the program at the Hospital. The development and implementa-
tion took place in seven phases from initiation of the program,
through completion/implementation, to a built-in requirement for on-
going periodic evaluation of the program.

The design of the program itself incorporated all of the best
elements of effective risk management programs which were gleaned
from in-depth review of nearly 120 health care journal articles and
interviews between numerous risk management experts and the program
project officer.

The major aspects of the program are being disseminated to Hospital
personnel through two primary vehicles: (1) educational briefings on
the risk management program t all hospital personnel, and (2) Hospital
Regulation 168-X, Risk Management Program, which will be published in
early May, 1980, and will be available to all Hospital personnel.

The effectiveness of risk management programs are based, in large
measure, upon two important factors. One factor is the SYSTEM, the
other is the PEOPLE. Regardless of the viability of a risk management
system, the people make the system function. The author cf this prob-
lem solving project believes the risk management system established

at the USAF Academy Hospital has the potential of becoming an

extremely effective program. The organizational components

have been carefully laid out; however, the crucial factor which

will determine the effectiveness and the future viability of the

program, is the entire hospital staff. The program requires

commitment, responsibility and work.

The Appendixes provide in-depth information and instructions

which can facilitate the work to be accomplished.

APPENDIX A

DEFINITIONS

1. RISK MANAGEMENT (RM). Risk management is the collective effort of
health care providers, hospital personnel and related advisors, to
minimize avoidable patient harm and hospital liability through a
structured program of problem identification and resolution, and
coordinated quality assurance.

2. RISK MANAGER. A risk manager is the individual, designated in
writing by the Hospital Commander (or chief executive officer in
civilian hospitals), who is responsible for coordinating the hospi-
tal's risk management program.

3. RISK MANAGEMENT COMMITTEE. The risk management committee is the
group established at each hospital having the responsibility to review
risk management matters for that facility, and the authority, subject
to the approval of the Hospital Commander (or chief executive officer
in civilian hospitals), to direct appropriate corrective action.

APPENDIX B

INTRODUCTION

While public and political pressures on hospitals to contain costs are mounting, hospitals today face a costly and complex risk control problem. The problem is manifested in four concerns:

(1)   the need to prevent injury or damage to patients, personnel, visitors, buildings and equipment;

(2)   the accelerating cost of obtaining workers compensation, malpractice and general liability insurances;

(3)   the increasing volume of law suits against hospitals and the concomitant need to protect the corporate assets; and

(4)   the need to comply with a multitude of regulations and enforcement agencies, i.e., JCAH, OSHA, state licensure, local building codes.

The "malpractice crisis" of 1975 focused attention on the need for hospitals to implement policies and practices addressing these concerns. Subsequently the rapid rise in malpractice premiums abated.

However, many experts in the field indicate that the health industry has only been in a "lull before the storm." James Ludlam, legal counsel for the California Hospital Association, suggests that another malpractice crisis is imminent in 1980-81 which will far exceed the 1975 crisis. (Malpractice Lifeline, Vol. 3, No. 15).

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THE APPROACH

The key activities of risk management include: (1) identification and analysis of the
organization's exposure to risk--determining the types of losses that are likely to occur
and the cost of such losses; (2) risk avoidance--adopting methods of operation to eliminate
a specific risk; (3) injury/loss prevention and reduction--implementation of loss control
procedures, employee safety programs, etc.; (4) loss retention and transfer of risk--evaluate
the best methods of paying for losses incurred.

To perform these activities, an organization must have adequate information available
to permit the development of a profile of its loss experience, to detect trend patterns,
to implement preventive measures, and to make prudent financial decisions.

The cooperative risk management program will provide resources to assist participating
institutions in performing the activities of risk management. A model program concept,
technical and administrative assistance in managing the program, and a data processing
system will be provided.

The technical component of the model will provide a structure for central coordination
of the quality assurance and risk control activities, as depicted in Illustration II. It will
prescribe appropriate policies and procedures to assure that all elements and activities
of risk management are provided. It will provide counselling and inservice education
for trustees, management, medical staff and personnel to assure understanding of the
risk management activities and to assure that the staff is trained to function in accordance

The cooperative program will employ personnel
with expertise in administering risk management, in loss control and quality assurance,
and in education. Medical consultants will be retained to assist in orienting medical
staff and in providing continuing medical education.

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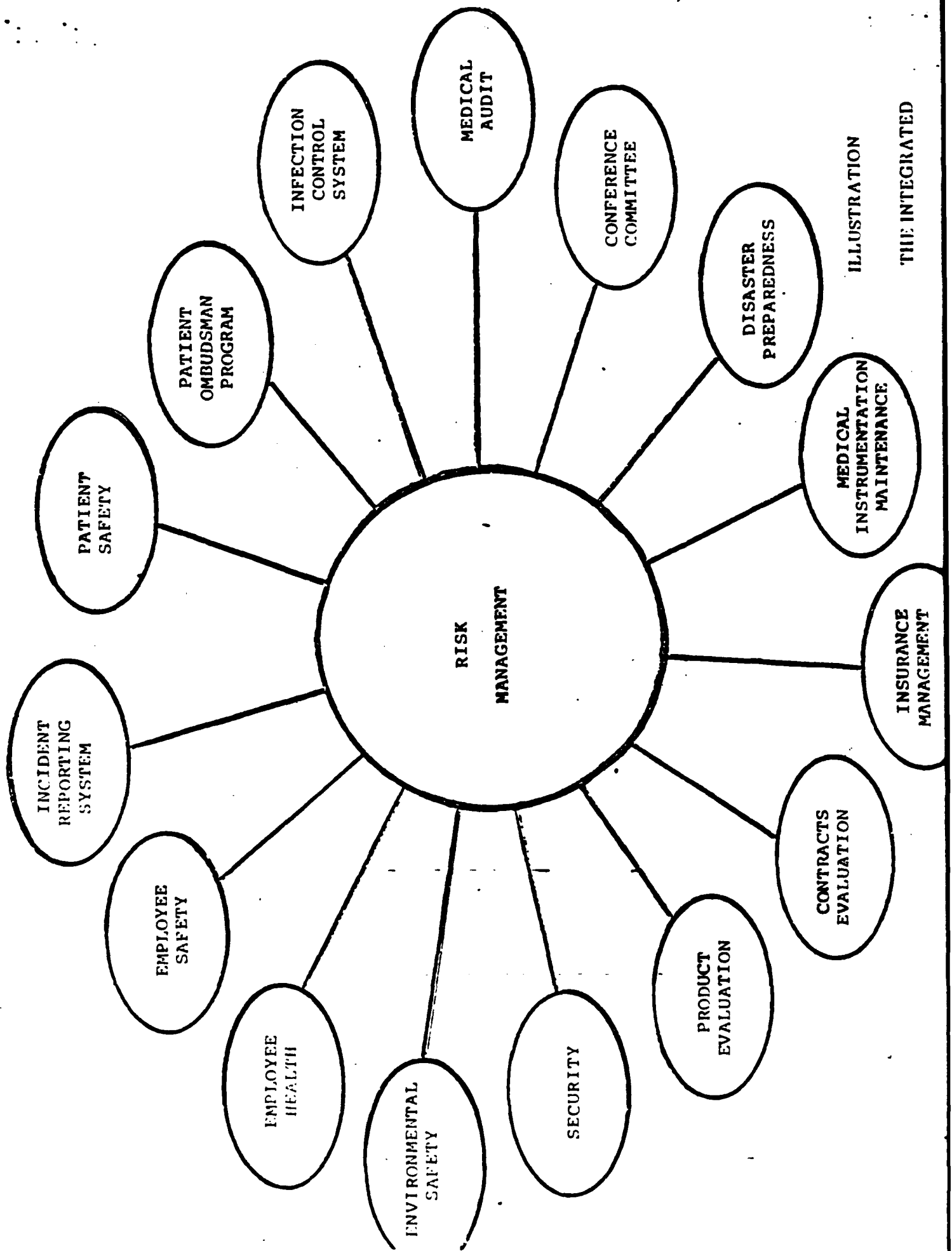   Trustee, 32:4 (Apr 79): 10-13.

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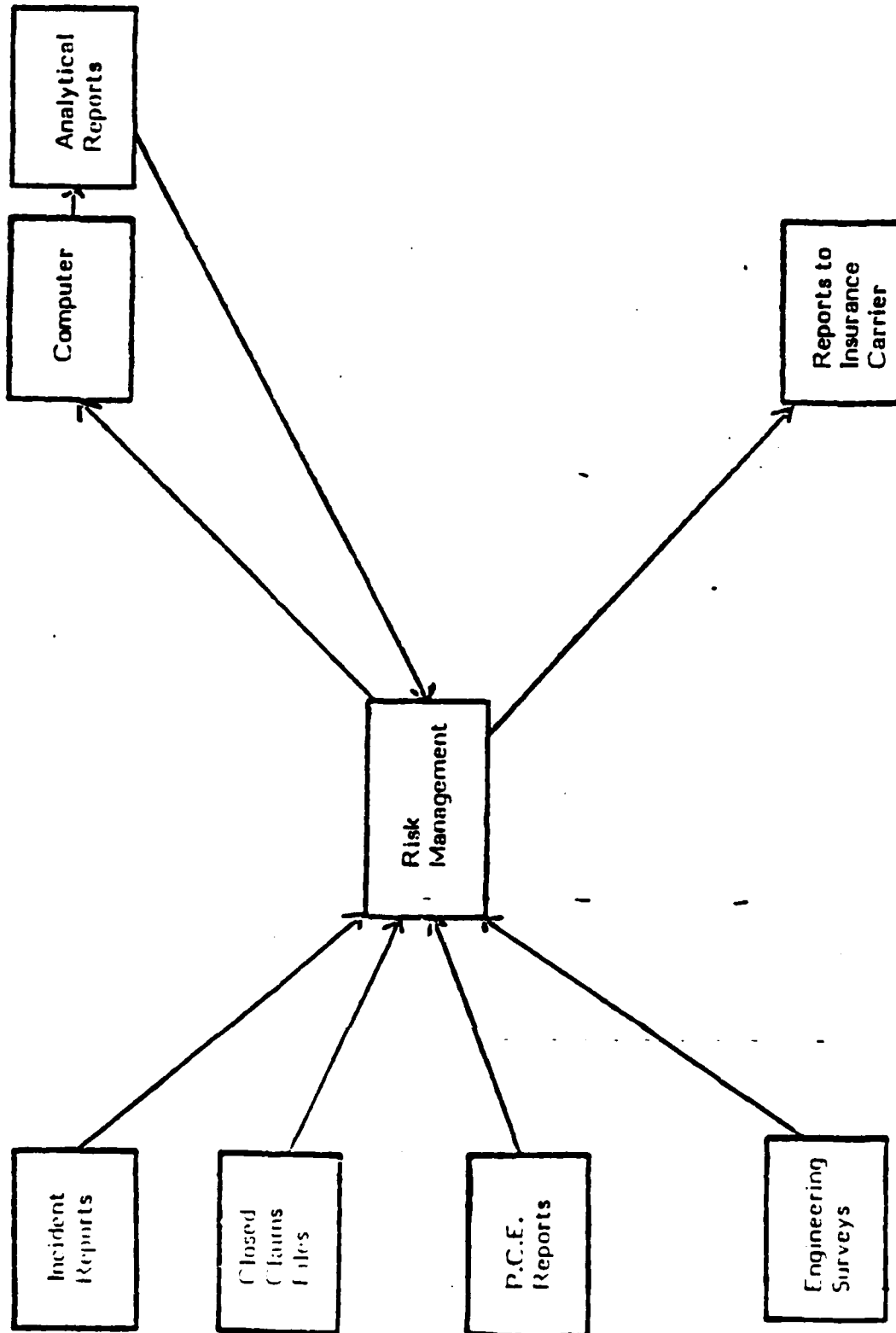cal Incidents," Hospitals, 52:14 (Jul 16, 1978): 83-88.

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THE INTEGRATED

ILLUSTRATION

RISK MANAGEMENT

- MEDICAL AUDIT
- INFECTION CONTROL SYSTEM
- CONFERENCE COMMITTEE
- PATIENT OMBUDSMAN PROGRAM
- DISASTER PREPAREDNESS
- PATIENT SAFETY
- MEDICAL INSTRUMENTATION MAINTENANCE
- INCIDENT REPORTING SYSTEM
- INSURANCE MANAGEMENT
- EMPLOYEE SAFETY
- CONTRACTS EVALUATION
- EMPLOYEE HEALTH
- PRODUCT EVALUATION
- ENVIRONMENTAL SAFETY
- SECURITY

ILLUSTRATION

RISK MANAGEMENT INFORMATION FLOW

IMPLEMENTATION IN PILOT HOSPITALS

<u>Step 1</u>

1. Initial audit

   The audit team[1] will visit each pilot hospital to review indepth its policies and procedures, its quality assurance and loss control mechanisms, its loss experience files, its current funding practices, its information system and all other activities related to risk management. A physical inspection of facilities and equipment will be conducted.

2. Audit report and recommendations

   The audit team will produce a report of its findings and recommend changes necessary to facilitate implementation of the risk management model

<u>Step II</u>

1. Program staff will assist in implementing changes recommended in the audit report.

2. Medical consultants will conduct orientation of the medical staff.[2]

3. Program staff will provide orientation, counselling and inservice education for trustees, management and line staff.

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Footnotes

[1] The audit team will be comprised of the program director, a loss control specialist, the medical consultant, a computer specialist and Clinical Engineering Service personnel.

[2] Involvement of the hospital's medical staff in the risk management system is essential. Studies have shown that a significant proportion of claims in the malpractice area result from the activities and conduct of physicians. Since the institution is held liable under law for safe and adequate patient care, the hospital must assume a leadership role with respect to preventing medically-related injuries. The Cooperative Risk Management Program will involve medical staff leadership in the early stages of planning and implementation. A medical consultant will be utilized to assist in medical staff education concerning risk management. Medical staff activities relevant to prevention of medically-caused injuries will be integrated into the risk management system; included will be committees such as medical audit, tissue and infection which may make a material contribution to quality of care.

[3] Typically hospitals have several committees of the administrative and medical staffs which relate directly to the risk management system. These may include safety, risk management, medical audit, credentials, infection, disaster and others. It is essential that their activities be integrated into and coordinated with the risk management system. The role of program staff will be to educate committee members concerning risk management and to bring about assimilation with minimal trauma.

3. Hospital Data (Please provide 1979 actual or average data)

Total Beds _____

Short term beds _____

Long term beds _____

Psychiatric beds _____

Bassinets _____

Occupancy _____%

Inpatient admissions _____

Outpatient visits _____

Emergency visits _____

Expense Budget $_____ (most recent annual)

Number FTE personnel *_____
    (two part-time equal one full-time person)

4. Facilities/Services (please check those that apply)

_____ Postoperative recovery room	_____ Hemodialysis
_____ Intensive care unit	_____ Abortion service
_____ Heart surgery facilities	_____ Patient representative services
_____ X-ray, cobalt, radium therapy	_____ Alcoholism/chemical dependency unit
_____ Pharmacy	_____ Respiratory diseases unit
_____ Respiratory therapy	_____ Pediatric unit
_____ Emergency room	_____ Orthopedic services
_____ OB-Gyn	_____ Long term beds
_____ Premature nursery	_____ Other special services
_____ Neonatal intensive care unit	_____
_____ Burn care unit	_____
	_____

9. ____Yes ____No   Do you now have a risk management committee?

If yes, briefly describe responsibilities and composition including names and titles of members:

_____

_____

_____

_____

_____

_____

10. ____Yes ____No   Do you now have a person on your staff responsible for safety activities?

____full-time

____part-time

name & title _____

11. ____Yes ____No   Do you now have a person on your staff responsible for risk management activities?

____full-time

____part-time

name & title _____

12. ____Yes ____No   Do you now have a person on your staff responsible for quality assurance activities?

____full-time

____part-time

name & title _____

*As stated in the cover memorandum, each pilot hospital will be required to provide a statement adopted by the Board and Medical Staff indicating the hospital's commitment to the Program and to the concept of risk management. A sample resolution is enclosed to assist you in formulating such a statement.

APPENDIX C

EXPOSURE DRAFT

POSITION DESCRIPTION

HOSPITAL RISK MANAGER

Purpose of Position:

To coordinate all aspsects of risk identification, evaluation and treatment within the hospital.

Nature and Scope:

This position reports directly to the hospital administrator.

The risk manager is responsible for overseeing the risk management activities of the hospital. Such activities include:

1. the analysis and investigation of actual and potential risks in the institution.

2. the establishment of methods to avoid, reduce or minimize risks.

3. the review of loss control methods with the department heads, chiefs of the medical staff, and the safety director who are responsible for their implementation.

4. the chairing of the risk management committee.

5. the review of language in agreements between hospitals and their suppliers to assure that these suppliers and the manufacturers of the products they supply assume their proper share of liability if any products they supply prove to be defective. This should be performed in consultation with the hospital's legal counsel.

6. the coordination of all property and casualty insurance carried by the hospital.

A Note on Claims Management

The extent of the involvement that a hospital risk manager will have in claims management is dependent upon the type of insuring mechanism the hospital employs. If the hospital partially or totally insures with a commercial carrier, the hospital risk manager will likely have little or no participation in the claims management process.

If the hospital totally self-insures, the risk manager's activities in claims management will probably be extensive.
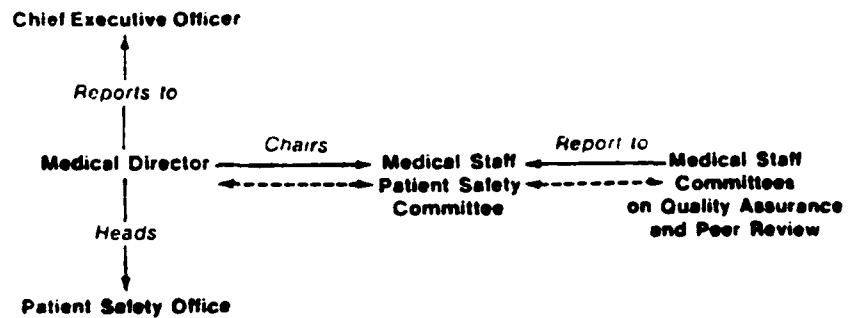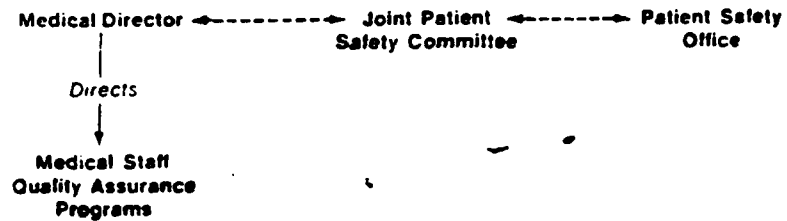
A Note on Staffing

The number of persons reporting directly to the hospital risk manager will be dependent upon the size of the hospital and the amount of time the risk manager devotes to risk management activities (whether it is a full-time or a part-time job).

A Note on the Background and the Previous Experience of
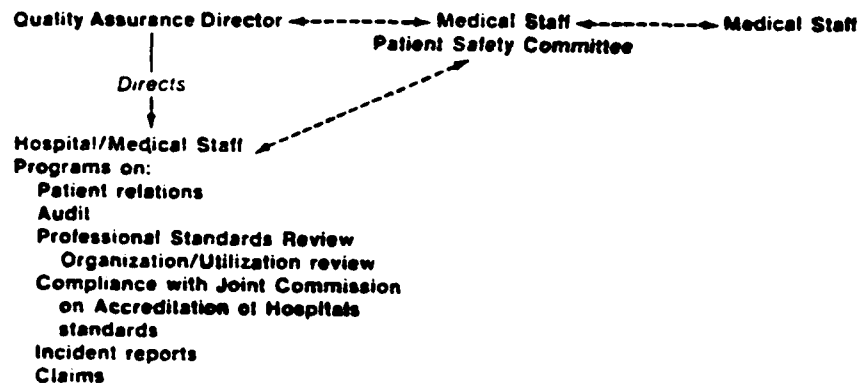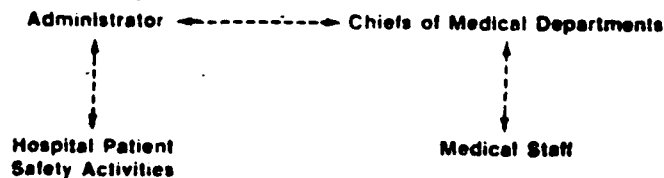the Hospital Risk Manager

AHA recommends that the person selected to fill the hospital risk manager position
have previous experience in the hospital. Backgrounds in hospital administration,
nursing, or medical record administration have been suggested. Because risk
management stresses the risk prevention activities that should occur as pre-
liminaries to insurance, AHA believes that that the risk manager's background
should demonstrate awareness of the actual problems encountered in the delivery of
health care services in preference to familiarity with the theoretical exposures
to risk common to all situations in which liability may occur.

. . . .

APPENDIX D

Medical Director Model I

Chief Executive Officer

Reports to

Medical Director ——*Chairs*——► Medical Staff ◄——*Report to*—— Medical Staff
◄- - - - - - - - ► Patient Safety ◄- - - - - - - ► Committees
Committee on Quality Assurance
and Peer Review

Heads

Patient Safety Office

Medical Director Model II

Medical Director ◄- - - - - - - ► Joint Patient ◄- - - - - - ► Patient Safety
Safety Committee Office

Directs

Medical Staff
Quality Assurance
Programs

Model patient safety systems. Broken lines indicate flow of communication

Quality Assurance Model

Quality Assurance Director ◄- - - - - - - ► Medical Staff ◄- - - - - - - ► Medical Staff
Patient Safety Committee

Directs

Hospital/Medical Staff
Programs on:
   Patient relations
   Audit
   Professional Standards Review
      Organization/Utilization review
   Compliance with Joint Commission
      on Accreditation of Hospitals
      standards
   Incident reports
   Claims

Administrator/Department Chiefs Model

Administrator ◄- - - - - - - - ► Chiefs of Medical Departments

Hospital Patient
Safety Activities

Medical Staff

APPENDIX E

Steps in the Establishment of a Liability Control System

The following eight steps provide a route to a liability control system. Each step must be addressed, but not necessarily in the order presented. Step 2, which is ongoing, must be pursued concurrently with steps 3, 4, and 5. Steps 2 and 6 are closely related in establishing a liability control system.

Step 1. Obtaining top-level commitment

Step 2. Integrating training and education programs

Step 3. Identifying high-risk priorities

Step 4. Establishing and refining policies, procedures, and documentation

Step 5. Choosing and implementing an organizational model

> Concurrent Steps

Step 6. Improving physician-patient-nurse-hospital communications

Step 7. Improving post-claims coordination

Step 8. Evaluating the system

Step 1. Obtaining Top-Level Commitment

As with anything else, a liability control system will not work without top-level management commitment. The hospital board, the chief executive officer, and the medical staff must recognize the need to curb the costs of liability claims—the financial as well as the human costs.

Hospital leaders need minimal persuasion that a serious problem exists. They are familiar with much of the data on claims and insurance premiums and know well the pressures from government, consumer groups, and the health care professions. The question they want answered, and answered in the affirmative, is "Will a liability control system work?"

Hospital liability control is a new concept. There are few data, and there is no assurance that a liability control system will result in fewer injuries or accidents or lower insurance premiums. However, as Leslie Sandlow, M.D., of the Michael Reese Hospital and Medical Center, Chicago, points out, "I'm concerned with quality, and the only way I can look at the whole problem of cost containment, malpractice containment, or accident contain-

Step 2. Integrating Training and Education Programs

Training and education relate to liability control in several ways. Once a system is established, all concerned members of the health care team need to be trained in its operation. In addition, all members of the health care team must be able to recognize the people failures, errors, and other deviations from the norm that could lead to liability claims.

Donna Rogers, formerly an administrator at Downstate Medical Center, Brooklyn, NY, points out that the hospital's greatest weapon against liability is education, and education should focus on actual cases against the hospital. "When you say to a group of physicians, 'We lost this case for $90,000. What can we learn from it?' you have their attention," she explains.

Both before and after a system is implemented, training is needed to improve skills in the subsystems of liability control, such as medical audit, nursing audit, medical records, incident reporting, communication, and safety control.

In-service training and continuing medical education programs should be considered within the liability control framework.

It is expected that the individual or committee responsible for liability control would prescribe training and education to remedy deficiencies that might lead to liability claims. In some cases, training might be the only action indicated; in other instances, training might be one of several remedial actions.

The examples in figures 4, 5, and 6, below and next page, illustrate how training and education might be prescribed to reduce people failures that may lead to liability.
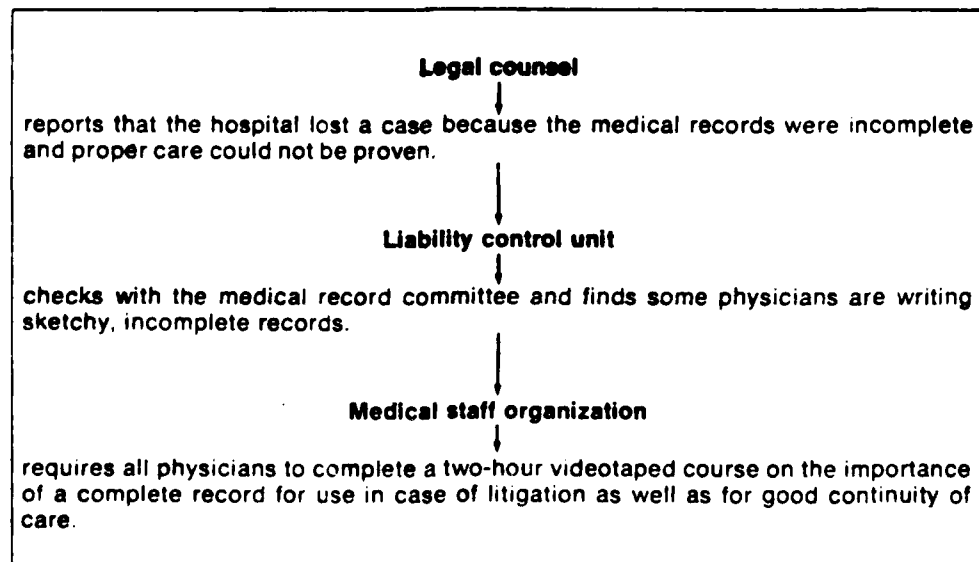
Legal counsel

↓

reports that the hospital lost a case because the medical records were incomplete and proper care could not be proven.

↓

Liability control unit

↓

checks with the medical record committee and finds some physicians are writing sketchy, incomplete records.

↓

Medical staff organization

↓

requires all physicians to complete a two-hour videotaped course on the importance of a complete record for use in case of litigation as well as for good continuity of care.

Figure 4. Addressing Incomplete Medical Records through Training

Step 3.   Identifying High-Risk Priorities

To utilize limited resources most effectively, the hospital should identify the most likely areas or procedures that expose the hospital to the filing of claims. A liability control approach should concentrate first on these high-risk priorities. Through the process of analyzing past records to identify high-risk areas, the hospital will create the rudiments of a data-gathering system.

Actually, the data-gathering function serves twin purposes. By centralizing all information related to a claim, it provides the basis for a complete, accurate file for legal purposes in the event the hospital must defend its care. In addition, the data can be analyzed periodically to identify the hospital's high-risk priorities.

In the beginning, the hospital may need to rely on external sources of data to hypothesize about the nature and location of its high-risk priorities. These sources include studies by insurance carriers and national associations. Gradually, the hospital will build its own data base from incident reporting, patient complaints, medical audit, actual claims, and other information. After a year or two, the hospital will be able to pinpoint its unique high-risk priorities.

Developing a Data Base

The liability control unit should immediately begin to compile a data base that includes:

1. Areas of the hospital where incidents are frequent (for example, emergency department)

2. Medical specialties and procedures that result in claims more frequently than most (for example, anesthesiology or surgery)

3. Situations that appear to be associated with claims (for example, improper instructions upon discharge or incomplete medical records)

4. Sources of information concerning the possible liability (for example, medical audit, incident report, and so forth)

An analysis of these data will allow the hospital to identify its high-risk priorities. It can then formulate remedial actions. As the liability control unit receives input from incident reports and other sources, the data must be fed into the growing data base. Later, the hospital must reevaluate the data to determine whether its actions have been effective and what additional actions, if any, are required.

The data base might be computerized or manual, depending on the size of the hospital. If the system is manual, regular summary reports must be prepared.

New York's Downstate Medical Center, Brooklyn, uses a cross-reference system for incident reports that compiles data by unit, physician, and type(s) of incident (for example, falls, medication error, misdiagnosis). In at least one instance, the cross-reference approach spotted a potential liability

In the future, more data will be available to hospitals. A study in California will screen 50,000 random medical records to determine a "raw injury rate," regardless of whether a liability claim has been filed. An insurer for more than 30 Maryland hospitals has begun to prepare loss analysis information on the specific location and other aspects of liability claims.

Table 1.   What Diagnosis Led to the Claim?

Final Diagnosis of Original Condition	Percentage of Paid Claims	Percentage of Indemnity
Injuries and adverse effects	18	14
Diseases of digestive system	10	10
Misdiagnosis for which treatment rendered	8	10
Diseases of the genitourinary system	7	8
Delivery and complications of childbirth	7	8
Diseases of the circulatory system	6	6
Diseases of the musculoskeletal system	6	7
Signs, symptoms, and ill-defined conditions	5	5
Diseases of the respiratory system	4	4
Diseases of the nervous system	4	5
Others		

This table refers to the diagnosis made *after* the incident, not the condition diagnosed on admission or the condition that caused the claim

Source: *NAIC Malpractice Claims*, vol. 1, no. 2, Apr. 1976, p. 15.

Table 2.   What Error in Procedure Was Involved?

Error in Procedure	Percentage of Paid Claims	Percentage of Indemnity
Improperly performed	45	42
Occasioned by misdiagnosis	8	10
Better alternative	7	8
Delay	6	10
Not performed	5	5
Contraindicated	4	6
Not adequately indicated	4	3
None	22	15

This table shows the frequency and severity of claims in terms of diagnostic and therapeutic procedures. In 78 percent of paid claims, some error in procedure may have caused injury; in 22 percent, an error was not involved.

Source: *NAIC Malpractice Claims*, vol. 1, no. 2, Apr. 1976, p. 61

Table 3.   What Procedure Caused the Injury?

Procedure	Percentage of Paid Claims	Percentage of Indemnity
Surgery—female genital system	13	10
Diagnostic—therapeutic procedures	12	11
Surgery—musculoskeletal system	12	15
Surgery—digestive system	10	13
Treatment and drugs	9	10
Surgery—nose, mouth, larynx	6	5
Anesthesia procedures	5	11
Surgery—skin, subcutaneous tissue	4	1
Surgery—male genital system	3	2
All others	26	22

This table refers to surgical procedures that are associated with many injuries. In some cases a number of factors may have contributed to the injury

Source: *NAIC Malpractice Claims*, vol. 1, no. 2, Apr. 1976, p. 27

look should be given to the medical staff bylaws. What procedures are allowed for dealing with professionals whose deficiencies are disclosed through the liability control system? The hospital can be hurt from *both* sides.

- Hospitals have been found liable and paid damages when, hampered by bad bylaws, they did not provide due process (including a fair hearing) for physicians faced with charges that could lead to a denial of privileges or to dismissal.

- Hospitals have been found liable for allowing an unfit physician to be admitted or to continue to practice in the hospital. The hospital board is legally accountable for the hospital's performance, and the hospital and medical staff bylaws must be written to permit the board to exercise its legal authority to avoid such liability.

A review of safety procedures is part of traditional risk management strategies. It should not be overlooked in a more sophisticated liability control system. A large number of incidents involve breakdowns in basic safety procedures.

At a minimum, the hospital's safety program should include:

1. A safety orientation program for new employees

2. In-service and continuing education programs

3. Incident reporting and follow-up in order to document and correct unsafe procedures

4. Special safety programs on new equipment

5. Written safety rules

The hospital should designate a safety officer to be responsible for the safety program. A safety committee composed of representatives from various services should review incident reports and, where necessary, recommend changes in procedures or continuing education programs to minimize future incidents. Safety should be emphasized in patient education as well as employee education programs. Many falls and other accidents occur when patients fail to follow or understand instructions related to their safety.

The safety officer and the safety committee interact with the liability control system in two ways. First, the liability control unit refers all safety-related matters for investigation or remedial action. Second, the safety officer should call to the system's attention any potential liability problems that require more than a safety response.

For example, the safety committee might find that some employees were not being sent by supervisors to required safety courses. The liability control unit could help ensure not only that the services involved comply with the attendance requirements but also that the employees are checked out on what they learned when they return to the job.

Obviously, no safety program can stop all accidents. However, an effective liability control system can invigorate this traditional hospital effort to reduce incidents and to protect patients.
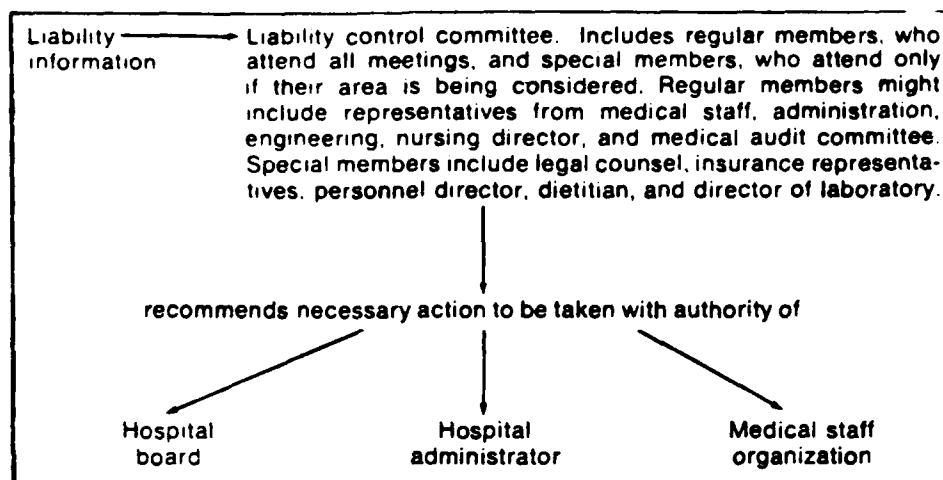
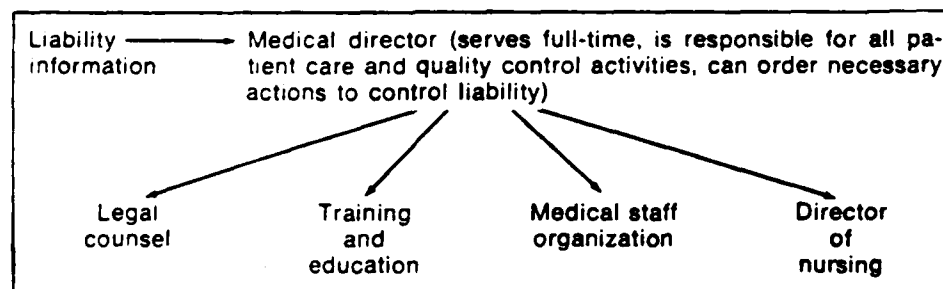Figure 8.   Committee at the Core of the Liability Control System

Figure 9.   Medical Director at the Core of the Liability Control System

Participants at a liability control seminar conducted in June 1976 by the Maryland Hospital Education Institute were divided in opinion between administrative and committee control. Some 17 of the administrators and physicians chose the committee model, 16 selected the administrative model, 6 opted for medical staff direction, and 8 said the board held accountability but should delegate day-to-day responsibility.

No matter what organizational structure is used, the time factor is critical. Liability control is a daily process. The accountable organizational unit must receive input on potential liability within 24 hours after an incident occurs and must take necessary action within 24 hours after receipt of the information.

For every incident, the liability control office must promptly establish a central file that includes all documentation, particularly the names of all hospital staff and physicians involved. It is important that the hospital know the parties involved because many claims are filed against the hospital and a "John Doe" staff member. Without a complete file, the hospital may experience difficulty identifying who was involved, particularly when claims are filed months or years following an incident.

of hospital personnel and other persons—patients, visitors, volunteers—may contribute to this atmosphere."[20]

Recognizing the human dimensions of medical care enhances the quality of care, but it may also influence the hospital's liability experience. "All interaction with patients, from explaining the use of equipment to the manipulation of the bed rail can have liability consequences," says Peggy Berry.

Mitchell T. Rabkin, M.D., general director, Beth Israel Hospital, Boston, notes, "The patient's perceptions are influenced by all contacts with the hospital, not simply those with specialized clinical personnel."[21]

In a 1974 address to the Massachusetts Hospital Association, Dr. Rabkin said the patient's contacts in the hospital "grow in bewildering complexity." He enters somewhat anxious, if not outright scared, about the illness. He is then stripped of his clothes and given a restrictive set of rules: where he may go, what he may eat, and what he must *not* do. In a typical day, he might have contact with admitting personnel, several shifts of floor nurses, the attending physician, radiology and laboratory technicians, operating room nurses, house staff, aides, and volunteers. All the highly developed clinical procedures of modern medicine are focused on the patient. It is not surprising that this array of hospital rules, tests, instructions, and contacts holds a large potential for miscommunication.

The patient may become angry because no one knows when his physician is coming, no one can reach the physician to prescribe a stronger medication, or no one knows when surgery is scheduled. Some staff members are sympathetic about his pain; others don't seem to care. Perhaps one individual was cross when the patient asked a question, and now he is scared to ask anyone anything. Or perhaps the patient is irritated over a nonclinical problem: the television doesn't work, the admitting office can't find his insurance card, or whatever.

"A happy patient is a lower risk than an angry, tense patient," says Donna Rogers. "Making him happy can be accomplished by better communication and 'rehumanizing' the patient." Ms. Rogers says that patients "must be given an outlet to complain." And when a complaint bodes potential liability, the liability control system goes into action.

At Beth Israel, a hospital services manager attempts to help patients deal with the hospital system. A 24-hour hot line to the hospital services manager is open for problems that have to do with the patient's comfort or convenience; rather than problems of a medical or nursing nature. A number of hospitals have patient representatives performing similar services.

The following examples illustrate how communication breakdowns can lead to liability claims. In each case, a proper standard of care was delivered. Nevertheless, a bad outcome—or a perceived bad outcome—under these circumstances might well precede a liability claim:

- The patient who was scheduled for surgery at 8 a.m., but lay waiting outside the operating room until 11 a.m., during which time no one explained the reason for the delay.
- The patient who was not told of the possible side effects of a medication or the aftereffects of a test.

Step 7. Improving Post-Claims Coordination

No system of liability control can put an end to all liability claims. Some preventable occurrences will slip through any system. Some actual cases of negligence or malpractice will still occur. Therefore, the liability control system must also function *after* a claim is filed.

Traditionally, once a claim was filed, the insurance carrier and the attorneys had primary, if not exclusive, involvement. Physicians were consulted primarily to obtain favorable evidence. Some physicians were less than cooperative; many lacked documentation to prove that high-quality care was provided. If medical records, nursing notes, laboratory results, or other documentation were incomplete, the attorneys most likely shrugged their shoulders in disgust. They did not report their findings, for example, to the medical record committee to urge correction of deficiencies.

By incorporating post-claim activity into the liability control system, the hospital can:

- Provide key data to improve quality of care in the future.

- Develop as strong as possible a defense in the case at hand.

Whenever a claim is filed, the individual or committee responsible for liability control should ask the following questions:

- Did this case involve an incident that went through the liability control system? If not, why? If it did, were adequate steps taken at the time?

- Does the hospital or the physician appear to be liable?

- Do the facts indicate a need for the hospital to review any policies or procedures?

- Are the individuals named in the claim the subject of other pending or past claims? Is a review of their competence indicated?

- Could the hospital have done anything to prevent the occurrence that led to this claim? Can it do anything to prevent similar occurrences in the future?

- Does legal counsel have access to all essential documentation? Is the documentation adequate? If not, can deficiencies be corrected in this case and in future cases?

- What steps can be taken to reduce the possibility of the case going to a jury?

Figure 10, page 26, illustrates some of the possible post-claim interactions between a liability control committee and other elements of the liability control system. Some questions address reduction of liability in the case at hand; others address improvement of quality of care in the future.

Step 8. Evaluating the System

It is important that the hospital develop and use appropriate criteria to evaluate the effectiveness of the liability control system. Is the system reducing the financial severity of claims and the number of claims filed?

- The cost of the liability control system and its benefits (graphs of claims made, dollar losses, premium outlays).

The individual or committee responsible for liability control should evaluate these data on a regular basis, at least annually.

Dramatic results should not be expected right away. It may take a year or longer to install a liability control system. Moreover, the accumulation of malpractice claims, combined with outside pressures for increased litigation, will make it difficult for the system to reduce the number of claims and the financial severity of awards for some time.

It might be advisable for the evaluation process to separate the financial severity of claims filed before and after the system is installed. The hospital could also evaluate whether the system reduces the time and funds expended in defending the hospital against claims, particularly claims closed without payment.

The contributions of the system to improving the quality of care may be difficult to show in numerical terms, but are valuable and should be included in the evaluation.

Finally, it should be noted that liability insurance carriers will probably not reduce premiums until it is demonstrated that a liability control system has a statistically significant effect on reducing claims and awards.

APPENDIX F

PHYSICIAN INVOLVEMENT IN RISK MANAGEMENT

WILLIAM E. MITCHELL, JR., M.D.
PIEDMONT HOSPITAL
ATLANTA, GA

I. What do you want/need them to do?

   a. Serve effectively on committees

   b. Take good care of their own patients and avoid suits

   c. Handle documentation of "incidents" correctly

   d. Perform effective peer review

   e. Be effective advocates of the hospital in the community

   f. Not interfere with administration's Risk Management activities

   g. Bring perceived problems to attention of Risk Manager

   h. Teaching of patient care procedures/skills

   i. Other

II. Why won't they do it?

   a. Fear of peer rejection, respect for peer independance

   b. Resistance to dealing with non-physicians in positions of authority

   c. Time away from patients / family / other preferred activities

   d. Fear of further deterioration of physician-patient relationship due

      to intervention by others·

   e. Feeling that others (i.e. you) get paid to do it; why should they

      do it for free?

   f. Feeling that they have no "say" in running of the hospital, so

      why should they spend thankless hours helping the hospital?

   g. Other

III. How can effective involvement be encouraged?

   a. Document benefits of Risk Reduction   # incidents
                                             # suits
                                             premiums
                                             etc

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b. Don't overwhelm them with the whole Risk Management activity - get help on specific problems that they're interested in

c. Never waste their time on useless meetings, reports, etc.

d. Positive reinforcement - prestige, smiles, letters, results, etc.

e. Separate review and action activities as much as possible to reduce peer anger

f. Personal appeal; to do this you have to be liked/respected

g. Handle their pride/fears with understanding

h. Remember that your full-time activity is a minor part of their work. Have realistic expectations re:time, dedication and know-how on their part

i. Consider ways to increase their "say" in how the hospital is run

j. Don't give up!

APPENDIX G

THE ROLE OF MEDICAL RECORD SERVICES
IN RISK MANAGEMENT

Because it contains a continuous account of what happened to
a patient during his hospital stay, emergency treatment, or
outpatient visit, the medical record is the most important tool
for problem identification in quality assurance and risk
management (QA/RM) activities and in malpractice litigation.
For this reason, the Medical Record Department (MRD) of any
hospital controls the largest data base for use in a QA/RM
program. An accurate high quality medical record is essential
to such a program, and the MRD and Medical Record Department
Administrator (MRDA) should play an active role in the implemen-
tation and maintenance of a hospital's QA/RM program. MRD
participation could range from providing minimal support to
managing all QA/RM activities. If MRD participation in QA/RM
activities is expanded to include such management, the MRDA must
be knowledgeable in evaluation techniques, data management
activities, and risk management functions. His or her knowledge
of medical record data and expertise in data retrieval and
analysis can greatly enhance the effectiveness of a QA/RM
program.

Consequently, the MRD can become the hub of a hospital's QA/RM
activities and should be an integral part of a QA/RM program,
whether or not it assumes full responsibility for the coordination
of these activities. In either case, the MRD should:

- Develop an early warning system

- Assure the quality of medical records

- Assure the confidentiality and accessibility of
  records that represent potential or actual lawsuits

- Coordinate legal correspondence and release of
  information

- Provide appropriate inservice education

Policies and procedures that relate to each of these areas must be
formulated carefully and must have substantial input from hospital
administration, the medical staff, and the risk manager (if
applicable). The scope and purpose of each of these actitivies,
as well as suggested procedures, are presented in this supplement
to The Risk Management Primer, published by Care Communications, Inc.,
in May, 1979.

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R2

Example: Sample criteria used by one MRD to
screen records, identified records that
documented

- Secondary surgical procedures

- Temperature over 100.4 for three days post-
operatively or postpartum

- Hospital acquired infection

- Accidental puncture or laceration of
organs

- Postoperative hemorrhage

- Differences in medical opinion

- Death

b. The "focused discharge analysis" procedure is
used to screen all discharges. Cases failing
the criteria are referred to the risk manager
for evaluation and action.

c. A screening form should be filled out on those
records that fail to meet the screening criteria.

d. Code the cover of any record in which a PCE has
been identified so that the risk manager can be
notified whenever the record is requested by
anyone other than the insurance carrier.

e. Periodically, data should be collated and displayed
by type of problem. Such a display will allow
detection of patterns and should be done at least
annually, if not every six months.

2. Establish an Incident Report Cross Index

a. The correspondence clerk should be alerted whenever
information (other than insurance requests) is
requested on a patient for whom an incident report
has been filed.

b. A simple way to cross reference incident reports
would be to code (by letter or number) the master
patient index card in the MRD. Copies of incident
reports or a list of names of patients for whom
incident reports had been filed would therefore be
sent regularly to the MRD.

B. Procedures for Identifying and Solving Documentation
Problems Can Be Varied

1. Indepth record screening by the medical record or
risk management committee to evaluate content and
compliance with legal requirements

a. Using criteria based screening, review a
representative sample of all practitioners and
disciplines.

b. Use medical staff rules and regulations, JCAH
standards, and HEW conditions of participation
to formulate criteria.

c. Focus on different documents in the record for
each study (ie, discharge summaries for a medical
staff study, anesthesiologist records for an
anesthesiology study, etc.)

d. Take appropriate action when records do not comply
with established criteria. Actions for consideration
include

· Feedback

· Inservice education

· Warnings placed in credentials files

· Nonrenewed privileges after repeated attempts
to encourage improvement

2. Focused discharge analysis using audit study results

a. Traditional discharge analysis procedures should be
revised and expanded in scope to include analysis of
incomplete documentation by nurses, therapists, and
other nonphysician health care professionals.

b. The focused discharge analysis procedure should
also be used to monitor deficiencies revealed by
audit studies until identified problems are resolved.
Ongoing reports should be submitted to the risk
manager, appropriate medical staff, and appropriate
hospital committees:

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IV. COORDINATE LEGAL CORRESPONDENCE

A. Purpose

Subpoenas for records routinely go to the "Keeper of the Records" -- whether the patient is suing a third party or the hospital itself. Regardless of who are defendants or what caused the suit, the hospital can be a potential defendant in almost any case.

(Example: The parents of a youth shot by a policeman in Chicago last year are suing the City of Chicago, the Police Department, the policeman, and the hospital.)

For this reason, the risk manager should be notified automatically whenever a subpoena is received. All subpoenas and legal correspondence should be kept in the legal file.

B. Procedures for Coordinating Subpoenas and Legal Correspondence

1. Maintain a log that indicates when subpoenas are received, when the risk manager is notified, and when subpoenas are answered.

2. Guarantee that records taken to court are not lost

   a. Make a xerox copy of the record to take to court.

   b. If the judge or attorney wants the record to be submitted as evidence, ask if the xerox copy is acceptable (in some states a xerox copy is acceptable.)

   c. If the original document alone is acceptable, the hospital will at least have a copy during the litigation and if the original is lost.

   d. Maintain a tickler file for contacting the attorney periodically to request return of the original to the hospital.

3. Assist the hospital attorney and the risk manager to prepare interrogatories (lists of questions submitted to the hospital by the plaintiff's attorney to which the defendant must respond.)

   a. The MRDA can use her skills in data retrieval and knowledge of medical records to prepare the preliminary responses by reviewing the record.

In conclusion, the MRDA and MRD staff must become knowledgeable about the hospital's overall goals in quality assurance and risk management and should prepare to participate actively in problem identification, resolution, and prevention, and in educational activities for other hospital personnel. In addition, the MRDA must make certain that her department is operated efficiently, effectively and that all functions are accomplished accurately. The MRD itself should be checked for breakdown in systems (ie, record control, record completion, etc.) and the MRD must fulfill its vital responsibilities better than ever. Systems and records must be improved in response to the ever-increasing need for accurate, up-to-date medical records.

APPENDIX H

A SYSTEMS APPROACH
OCCURANCE ANALYSIS: A SYNOPSIS

CHARLES M. JACOBS
PRESIDENT
INTERQUAL
CHICAGO, IL

Occurrence screening, reporting and analysis provides an early warning of potential areas of malpractice exposure and permits determinations about how such exposure can be minimized — presently and in the future. To accomplish this task information concerning occurrences in the hospital that are not an expected consequence of patient medical conditions or medical intervention are reported and analyzed.

Occurrence screening and analysis is a major step beyond traditional incident reporting. This is because occurrence screening and analysis is pointed at adverse effects of medical management and not only at falls, burns and medication errors. Only by this more inclusive system can hospital risk management efforts have a meaningful impact on the disposition of claims and the success of loss prevention programs.

Underlying each actual or potential malpractice claim are plaintiff hypotheses regarding the severity and cause of injury and how it is attributable to the failure of the provider to perform up to the applicable standard of care. In the process of occurrence analysis the same circumstances that the plaintiff must rely upon to support the claim of negligence are made the bases of alternative hypotheses in which injury is minimized or negated and breach of duty or causality are excluded. An alternative hypothesis may account for the facts without assuming negligence, or may account for the facts by admitting such negligence but attributing the cause of the injury to some other and nonnegligent sources.

The steps in occurrence analysis are: First, identify adverse occurrences. Second, gather all relevant data about each occurrence. Third, with respect to cases showing significant patient injury, construe the facts from the claimant's viewpoint and determine what clinical hypotheses might form the basis for recovery. Fourth, review the same facts from the provider's viewpoint and determine what alternative clinical hypotheses might negate any or all of the possibilities of injury, breach of standards or causation. Fifth, decide upon risk treatment alternatives (e.g., early intervention versus using the fruits of occurrence analysis in the ordinary course of the claims process). Sixth,

are outcome oriented and hence describe expectations about the course of hospitalization and the consequences of care.

Each hospital should adopt the occurrence screening approach to its special circumstances by enriching the criteria in light of the high risks normally encountered locally. In this way, occurrence screening can become a powerful tool both for malpractice loss minimization specifically and for quality assurance in general.

The techniques for acquiring and analyzing occurrence data are now available and can be implemented as part of any hospital risk management program. Obviously, the same analysis techniques are even more applicable to actual claims. By applying these techniques immediately upon receipt of a claim, the medical staff and hospital gain a powerful defensive posture from the outset. Thus, systematic clinical analysis of occurrences and claims can be made the most cogent weapon in the risk management armaterium.

OCCURANCE SCREENING
MEDICAL MANAGEMENT ANALYSIS (MMA)

JOYCE CRADDICK, M.D.
CONSULTANT-PROFESSIONAL LIABILITY DIVISION
MARSH & MC LENNAN INC.
SAN FRANCISCO, CA.

Medical Management Analysis (MMA) is a professional liability
warning system designed to assist in the improvement of the
quality of patient care and reduce the likelihood of malpractice
suits. Proper implementation of MMA permits

1)   early identification and reporting of adverse patient occur-
     rences (APO's) for immediate evaluation and action,
2)   prevention of repetitive adverse patient events by continuous
     monitoring of, and timely action on, patterns of APO's,
3)   coordination of all hospital and medical staff efforts on
     quality assurance and risk management.

MMA is based on the concurrent review of medical records while
patients are still in the hospital, using a set of comprehensive,
objective outcome screening criteria that apply to all records
regardless of reason for hospitalization. Ambulatory screening
criteria have also been developed. The system permits screening
of all aspects of patient care and detection of problems relating
to both hospital and medical staff.

Initial record screening is done by non-physician personnel on a
regular, continuous basis. Review of records with variations from
the criteria is done by physician reviewers, either immediately
if serious, or within a specified time period if non-serious. When
APO's are confirmed by secondary screening, reports are channeled
to a program coordinator and/or a centralized hospital-medical
staff committee responsible for patient safety and quality assurance.
This person or committee will be closely linked to the claims manage-
ment and to other committees and departments of the hospital and
medical staff to assure prompt action and follow-up on problems.

The outstanding features of the MMA system which differentiate it
from many other risk management systems currently in use are:

1)   Physician involvement. (The majority of expensive hospital-
     based malpractice claims also name one or more physicians, and
     identification of physician-related events is essential.)

2)   Concurrent record screening, evaluation and reporting. (The
     more rapidly an adverse event is identified and acted upon,
     the lower the potential liability, and the less likely is
     the repetition of the event.)

3)   Coordination of all presently fragmented data collection,
     quality assurance and risk management activities into a time-
     and cost-effective program to meet both internal and external
     requirements.

4)   Flexibility of the system as it is adapted to the needs and
     problems of individual hospitals and medical staffs, and then
     adopted as their own program.

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IMPLEMENTATION MODEL
MEDICAL MANAGEMENT ANALYSIS
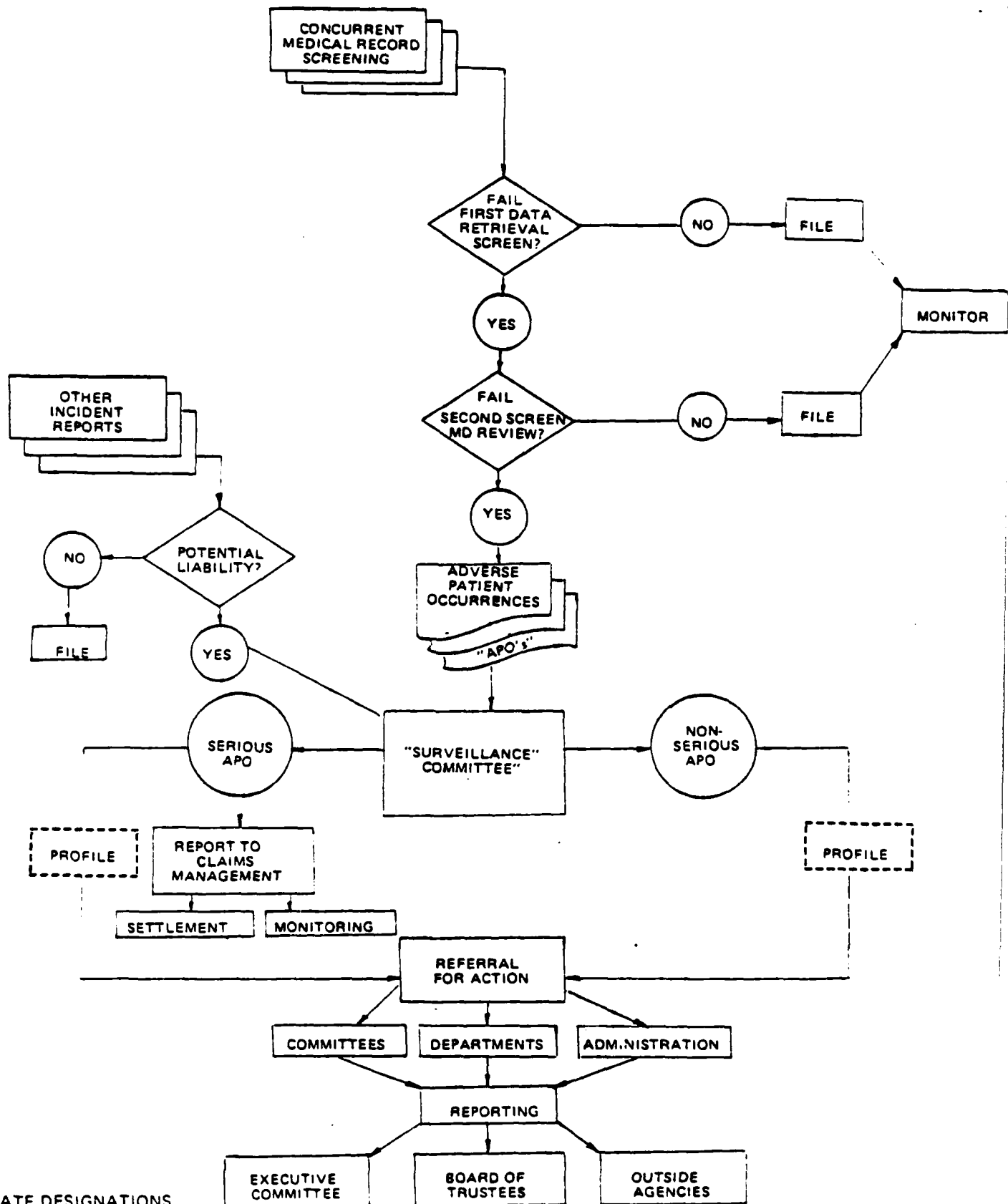
ALTERNATE DESIGNATIONS.

QUALITY ASSURANCE
PATIENT SAFETY
PROFESSIONAL LIABILITY } COMMITTEE
RISK MONITORING
LOSS CONTROL

GENERAL OUTCOME SCREENING CRITERIA SET FOR HOSPITALS

|	ELEMENTS	STD. 0%		EXCEPTIONS		INSTRUCTIONS FOR DATA RETRIEVAL
				OPTIONAL		
16.	Patient/Family dissatisfaction with physician care, hospital personnel care, other.	X	16A.	None.	16.	Check nurse's notes, progress note pt. complaint reports.
17.	Transfusions for conditions other than hypovolemia due to acute blood loss, chronic anemia < 5 gm. hemoglobin or exchange transfusion.	X	17A.	Hemoglobin over 5 gm. and patient is symptomatic.	17.	Documented acute blood loss with systolic BP decreased over 30 mm. Hg. or pulse rate increased over 20/min or documented over 1000 cc. surgical blood loss or note stat patient in shock. History docume chronic anemia.
			17B.	Emergency surgery in patient with less than 10 gm. hemoglobin.	17A.	Symptomatic = decreased BP, increased pulse rate, fatigue, dizziness, weakness.
					17B.	Admission note documents that procedure is an emergency.
18.	Pathology report (tissue diagnosis) does not match preoperative diagnosis.	X	18A.	No tissue removed or tissue non-diagnostic and clinical justification for surgery met.	18.	Compare preoperative diagnosis o lab. slip with pathology report.
					18A.	See list of surgery justification criteria.* If procedures not listed return record for review.
19.	Antibiotics for other than a matched culture and sensitivity or meets exceptions.	X	19A.	Culture taken, patient started on antibiotic(s) pending culture results.	19.	Compare orders and C&S report.
			19B.	Prophylactic antibiotics for: Patient with congenital or rheumatic heart disease, undergoing oral, GI, or GU surgery or vaginal delivery or Class IV surgery, total hip replacement, vaginal hysterectomy or placement of vascular prosthesis.	19A.	Check to see that antibiotic chan if necessary, after C&S reported.
					19B.	See history and physical. Class I surgeries are operations resulting in heavy contamination of previo bacteria-free tissue, e.g., ruptured appendix, penetrating wounds, gangrene or perforation in the abdomen. Check operative repor
20.	Medical record completed within required time and documentation adequate.		20A.	None.	20.	Check completeness and adequad of documentation according to hospital rules and regulations.
21.	(Departmental or other.)					

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† Clues to adverse results of outpatient management include delayed diagnosis (eg. first admission for advanced tuberculosis, metasta carcinoma; perforated appendix; severe diabetic ketoacidosis; shock; septicemia; any disease with systemic complications); any conditi attributed to outpatient drug therapy (eg. digitalis intoxication; hypokalemia while on diuretics; gastrointestinal bleeding while on aspir steroids, Butazolidin, Indocin; bleeding while on anticoagulants; Parkinsonism while on tranquilizers; anaphylaxis, drug reaction complications of procedures performed in the office, clinic or emergency room (eg. malunion, non-union, or complications of fractur irradiation burns; wound infections; physical defects; neurological defects; complications of physical therapy, x-ray, or laborato procedures or other outpatient procedures); any disease for which immunization available (eg. measles, mumps, polio, hepatitis, diphthe tetanus).

§ Incidents include medication errors, patient accidents, procedural errors, electrical shock or burn, intravenous errors, drug or contr material reactions, transfusion reactions, and actual or attempted patient suicide.

‡ Invasive procedures include intubations (tracheal, esophageal, gastric, rectal); percutaneous aspirations (thoracentesis, paracentesis, p cardiocentesis, bladder aspirations); percutaneous biopsy of heart, liver, lung, kidneys, prostate, etc.; catheterization of bladder, hea vascular system; x-ray procedures (arteriograms, renograms, ventriculograms, bronchograms, pneumoencephalograms); endoscop (bronchoscopy, cystoscopy, sigmoidoscopy, esophagoscopy, mediastinoscopy, peritoneoscopy, laparoscopy, culdoscopy, urethrosco ureteroscopy), pacemaker insertion; uterine sounding; enemas; and rectal temperatures.

* Developed by individual hospitals for most common surgical procedures performed.

APPENDIX I
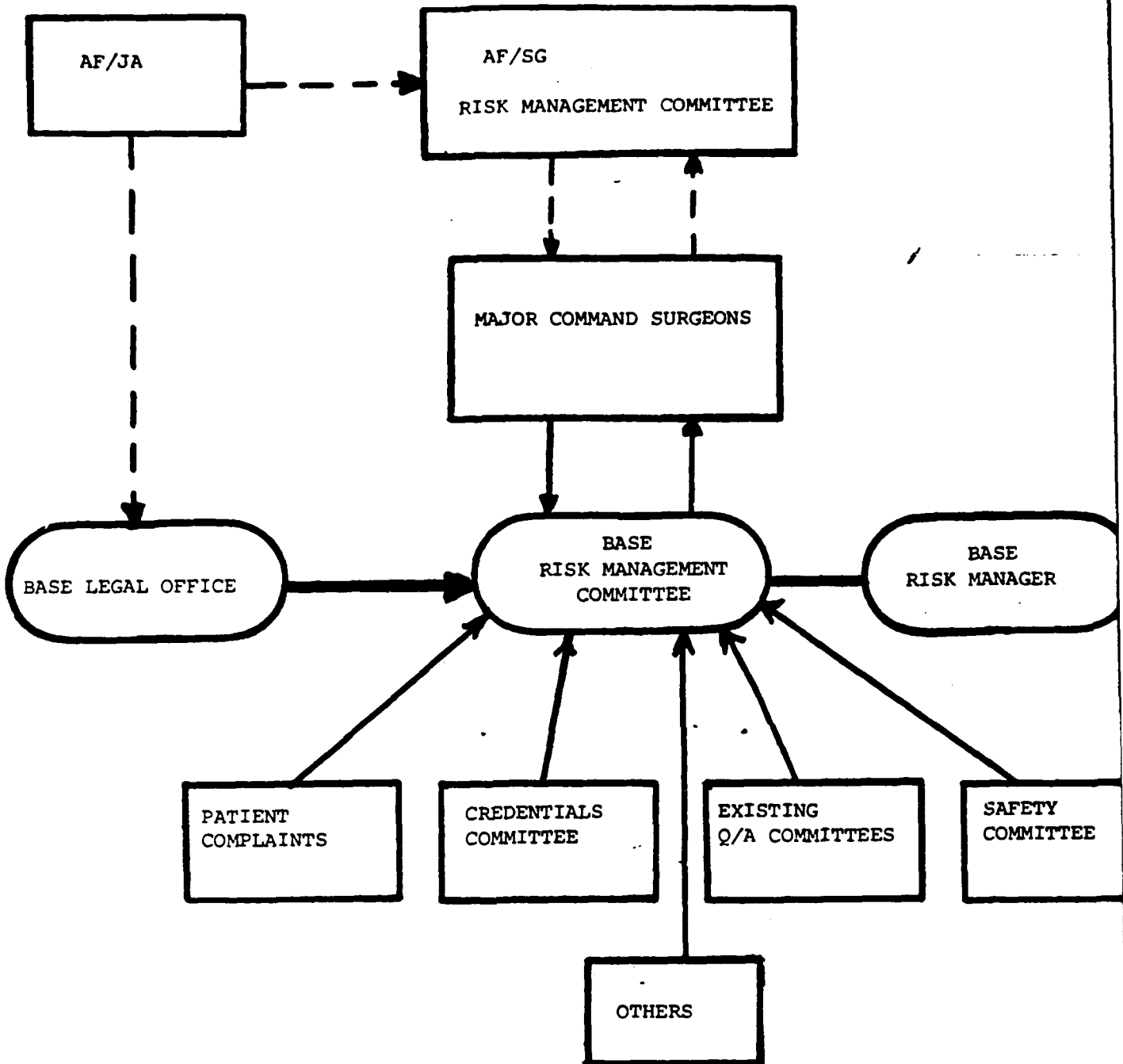
Air Force Risk Management Program Model

APPENDIX J

DEPARTMENT OF THE AIR FORCE   AF REGULATION 168-X
Headquarters US Air Force
Washington DC 20314   1 January 1980

Medical Administration

RISK MANAGEMENT IN MEDICAL CARE DELIVERY

This regulation outlines the policy and procedure for the operation of a risk
management program within the Air Force Medical Service.

with the risk manager on any potential claims arising in the medical facility (See para 10). The attorney will normally be the Base Claims Officer, unless otherwise designated by the Base Staff Judge Advocate. At Area Medical Centers, the assigned Medical Law Consultant (MLC) will serve as legal advisor to the committee; however, the Base Claims Officer should be fully involved in the program and remains primarily responsible for investigation and processing of potential and existing claims. The MLC will assist and consult on risk management matters for medical facilities within the MCL's geographic area of responsibility IAW AFR 110-30.

3. How the Risk Management Program Works - To achieve the policy expressed in paragraph 1, the Risk Management Program will involve three basic functions: identification and resolution of problems; education and sensitizing of hospital personnel; and optimizing patient relations. While responsibility for managing these functions lies with the Risk Manager and Risk Management Committee, the responsibility for supporting the functions lies with all hospital personnel.

a. Each base medical facility will have a designated risk manager and risk management committee. The Risk Manager is responsible for screening and coordinating information from various sources which identifies problems or potential problems in health care delivery. Numerous quality assurance functions, with specific areas of responsibility exist and operate effectively within the hospital. Numerous other sources exist which can provide helpful data (see para 7). The risk manager facilitates a comprehensive, centralized review of the problems surfaced by presenting the relevant information to the Risk Management Committee on a periodic basis. The committee will also receive periodic data on medical malpractice claims and other trends from HQ USAF/JA and HQ USAF/SG sources (see Section E). The committee will analyze the information and, subject to approval of the DBMS, direct appropriate evaluative or corrective measures. The committee also monitors the effects of its action as its ultimate responsibility is to assure that desirable results are, in fact, achieved in response to the identified problems for that particular facility. Urgency of certain problems may, of course, require modification of the timing or sequence in the normal flow of information described above. Problems identified, corrective actions taken, and ultimate results achieved will be documented in the committee meeting minutes, or attached to them. Copies of the minutes will be forwarded to the Major Command Surgeon and to the area Medical Law Consultant.

a. Potential Claims. (See para 10)

b. Incident Reports (See para 14)

c. Minutes of Safety Committee Meetings.

d. Committee minutes or reports from all quality assurance functions within the hospital, including reports of all audits performed. The risk manager is encouraged to attend committee meetings which surface patient risks within the facility.

e. Patient Questionnaires (See para 15), and patient complaints.

f. IG complaints.

g. Reports by external review groups (Inspector General, Joint Commission on Accreditation of Hospitals, staff assistance visits, military or civilian consultant visits).

Beyond these common examples, the risk manager may identify various other sources or functions in a particular facility which identify problems. In addition, informal factual reports, oral or written, may be made to the risk manager by hospital personnel.

8. Education of Personnel. Education of personnel in the concepts and structure of the risk management program in a particular facility is primarily the responsibility of the risk manager and the risk management committee. It will include, as examples, education on the use of the incident report, training on the importance and legal impact of records excellence, information on current developments in medical law, and recent claims experience within the Air Force.

9. Patient Relations. Good patient relations have become increasingly challenging and increasingly important. They often equate with effective patient-practitioner communications. The risk manager will serve as the coordinator for patient relations. He or she may establish operating guidance for responding to patient inquiries or complaints which best suits the facility involved. Such inquiries may be referred to appropriate departments or personnel when circumstances warrant, or may involve direct response by the risk manager.

12. <u>Meetings.</u> The Committee will meet at least quarterly. If disagreement exists as to appropriate action to be taken by the committee, recommendations will be made to the DBMS by a majority vote of members present. Minority recommendations may also be made. All actions are subject to approval of the DBMS.

13. <u>Responsibilities.</u> The committee serves as the decision makers for positive problem resolution within the facility. More than merely reacting to crises, the committee is responsibile for risk management program planning and to assure that appropriate quality assurance components exist and function effectively for the particular facility. Actions affecting the scope and conditions of practitioner's duties (credentialling) are set forth in AFR 160-41, Credentials Review of Health Care Providers; however, the committee should maintain close liaison with the credentials committee and may make recommendations to it. The scope of review of the committee is left within the discretion of the DBMS, but will routinely include:

a. A review of all agenda items presented by the risk manager or other members. In taking appropriate remedial action, the committee will assure that facility monitoring efforts, including medical audits, are directed towards priority and/or identified problem areas. In this regard, it will assure that the criteria used in medical audits are clinically valid.

b. Referral of problems to higher headquarters when the solution is partially or wholly beyond the scope of the committee. (See para 3a on referral of committee minutes generally).

c. Review of committee minutes of other committees within facilities for items involving risk management. In this regard, the committee will assure that all hospitals committees are aware of the risk management program and the responsibility to communicate appropriate items to the risk manager or risk management committee.

d. Support of risk manager in the education/training of hospital personnel. (See para S.) In addition, continuing medical education is to be directed to priority and/or identified problem areas.

a. AFMSC/SGP (Chairman)

b. AFMSC/SGPC

c. AFMSC/SGPA

d. AFMSC/SGS

e. HQ USAF/SGI

f. HQ USAF/SGN

g. HQ USAF/JA

In addition, the Council may consult with, or invite as an ad hoc member any specialist or other personnel determined necessary.

17. **Meetings.** The Council will meet at least semi-annually at AFMSC, Brooks AFB, TX.

18. **Responsibilities.**

a. Input to Council. The Council will establish procedures to receive pertinent information on risk-creating incidents or situations, including medical malpractice claims and litigation initiated, selected Congressional inquiries, and problem areas of general application within medical facilities.

b. Council Report (See para 3c). The council report will provide the Air Force medical malpractice claims experience for the semi-annual period involved, including identification of recurring claims, specific teaching cases, and current medicolegal trends as appropriate.

BY ORDER OF THE SECRETARY OF THE AIR FORCE

OFFICIAL

APPENDIX K

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
BOLLING AFB DC 20332

1 3 FEB

REPLY TO
ATTN OF: SG

SUBJECT: Air Force Medical Service Risk Management Program

TO: ALMAJCOM-SOA/SG

1. A short course was given to risk managers in November and December 1979. We have also completed preliminary coordination of the draft regulation (attached).

2. The Risk Management Program is to be implemented immediately. The attached draft regulation will serve as the interim guidance pending its official publication. While there are certain uniform requirements, each medical facility has the flexibility to accommodate to size mission and existing programs. Existing committees and other "problem identification systems" should be inventoried prior to establishing a tailored plan for implementation. Local operating instructions supplementing the draft regulation are permissible.

3. Medical staff involvement is important. The program cannot be successful without their legitimate participation. This participation begins with the realistic credentialling process. It should also sensitize all medical personnel to the malpractice problem and extend to all other activities of problem identification and resolution.

4. This program is important and necessary, and will require our most dedicated and sincere involvement.

FOR THE CHIEF OF STAFF

PAUL W. MYERS
Lt Gen, USAF, MC
Surgeon General

1 Atch
Draft Regulation

SG	
SGA	
SGH	
SGQ	
SGAA	
SGAS	
SGQT	

APPENDIX L

1 0 JAN 1960

SGAA (Capt Boone, 5105)

Risk Management Committee

The following personnel are designated members of the USAF Academy
Hospital Risk Management Committee:

H. Rolan Zick, Colonel, USAF, MC, Hospital Commander (ex-officio member)

James T. Shallow, Colonel, USAF, MC, Chief, Hospital Services (Chairman)

George A. Kaye, Colonel, USAF, MSC, Hospital Administrator

Robert M. Paull, Colonel, USAF, MC, Chief, Medical Services

Fay D. Parker, Colonel, USAF, NC, Chief, Nursing Services

Val J. Bateman, Major, USAF, MSC, Associate Administrator

Maston E. Martin, Captain, USAF, Legal Advisor

George M. Provost, Lieutenant, USAF, MSC, Plant Manager (Safety
Committee Representative)

H. ROLAN ZICK, Colonel, USAF, MC
Hospital Commander

APPENDIX M

Risk Management Committee Meeting

1. The Risk Management Committee meeting was held in the Hospital Conference Room at 1300 hours on   3 April 80.

2. The following members were in attendance:

Col Robert M. Paull	SGH	Chairman
Col H. Rolan Zick	SG	Member (ex officio)
Col George A. Kaye	SGA	Member
Col Fay D. Parker	SGHN	Member
Maj Val J. Bateman	SGAA	Member
Capt Maston E. Martin, Jr.	JA	Member
ILt George M. Provost	SGG	Member

3. Old Business:

   a. The "administrative burn-out program" for hospital personnel is pending Lt Col Fry's attendance at a class on this subject which is scheduled in April. Nursing Education provided an audiovisual presentation on this subject to hospital personnel in March. Approximately forty people attended. A video tape on "burn-out" is available in the hospital through Nursing Education. OPEN

   b. An ad hoc committee has been formulated for the review of emergency room records with Lt Col Strauss as chairman. Dr. Strauss and Lt Schmidt, P.A., review 10-20 percent of the emergency room records daily and compile a report of their findings to be submitted monthly to Col Paull for review at the Risk Management meeting. OPEN

   c. Lt Col Strauss is also preparing an emergency room treatment form. This form will incorporate all required emergency room information in blocks provided for specific information. It can be readily reviewed to determine if all blocks have been completed. This form should be available for committee review at the May meeting. OPEN

   d. The interaction of Quality Assurance and Risk Management was again discussed. Major Bateman stated that at the Risk Management workshop attended in March, it was proposed that risk management and quality assurance be totally separated; however, it was determined at this meeting that these two functions cannot be completey separated. Risk management could come under quality assurance audits which encompass many hospital functions. Col Paull recently attended a quality assurance meeting in Phoenix and noted that certain things are mandated under risk management in Air Force regulations and JCAH requires other items under quality assurance. Dr. Paull reviewed the attached chart (atch 1) outlining the functions within the hospital and to which committee each is responsible. At the present time, the Academy Hospital has not established a Quality Assurance Committee. Plans for this committee are pending guidance from HQ USAF. Composition of a Quality Assurance Committee may be very similar to the Risk Management Committee. Comments and specific recommendations on this subject are requested for presentation at the May Risk Management Meeting. OPEN

   e. A draft for a hospital regulation governing risk management is being prepared and should be ready for coordination in approximately two weeks. OPEN

   f. Arrangements are being made for presentations on risk management to various committees and nursing inservices within the hospital. On 9 April, Major Bateman will talk to the Professional Staff at their meeting. A date for a Nursing Inservice briefing

dissatisfaction in this situation could present a problem. He has discussed this with SMSgt Meland, NCOIC, Radiology and, as a result, a different type gown will be ordered. A second item discussed with Sgt Meland was the faulty door closures on the dressing rooms in the x-ray department, and a third item discussed was procurement of lock-boxes for storing of valuables while x-rays are being taken. All of these items contribute to patient satisfaction and diminished risk. OPEN
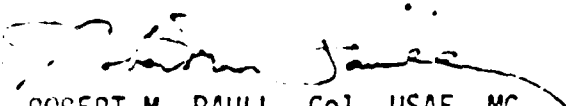
    b. Major Bateman reviewed four incident reports and stated that at the Risk Management meeting attended in New Orleans, it was noted that many hospitals are using "situation reports" rather than incident reports. It was believed by the administrators at these hospitals that their staff will more readily use this form for documentation of occurrence which should come to the attention of the risk manager. CLOSED
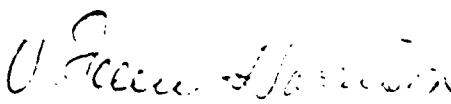
    c. Col Parker reviewed certain requirements outlined in OSHA Standard 127-8 involving patient care by ward nursing personnel. One of the items questioned by Col Parker was that patients with IVs and/or catheters must have siderails up when unattended. Col Parker stated that many patients would require bedrails to be in place most of the time. It was the committee's determination that criteria specified in this standard must be adhered to and nurses must be urged to follow the criteria inasmuch as the patient has this statement as backup in case of accident. CLOSED

    d. At the risk management symposium attended by Major Bateman and Capt Boone in March, there was confusion among attendees as to what risk management covers, however, it was noted that the primary purpose of risk management is prevention. Emphasis was made on risk management programs and informative literature, but the program primarily hinges on communication and awareness. The patient must be watched during the entire time in the hospital. Nursing staff functions, i.e., communication and interpersonal relationships geared toward patient satisfaction were emphasized. If a patient leaves the hospital satisfied even though something adverse has happened, he probably will not consider litigation. The provider has the initial contact with patients and should inform the patient of exactly what to expect while hospitalized. CLOSED

    e. An article on the responsibility for infection control within hospitals was recently published in a National Safety Council newsletter. The article was reviewed at the Infectious Disease Control Committee meeting and copies will be placed in the Providers' Handbook in the Risk Management section. CLOSED

5. The next Risk Management Committee Meeting was scheduled for 1300 hours on Wednesday, 7 May 1980. The meeting was adjourned at 1405.

ROBERT M. PAULL, Col, USAF, MC
Chief, Hospital Services
Chairman

V. Ellen Harrison
Recorder

1 Atch
Hospital Functions/Com. Responsibility
Chart

It was suggested that 5-10% of the total number of emergency room records should be reviewed each month to give a valid perspective. Colonel Kaye suggested an ad hoc committee be appointed, chaired by the Chief of the Emergency Room. This committee would review 3-4 records daily, make notations, and once a month report to the Risk Management Committee their observed findings/problems. If these records are reviewed each morning, it would not necessitate pulling and reviewing many records once a month. Dr. Paull will initiate formation of this ad hoc committee. OPEN

d. Major Bateman reviewed an article from the Quality Review Bulletin which lists criteria for an emergency room. He will provide copies of this item and others from this Bulletin with pertinent information for committee members. CLOSED

e. Dr. Zick suggested that possibly a special form to be completed by emergency room personnel should be devised. It is believed that if certain questions required specific answers on a special form, all avenues would be covered such as allergies, current medications, home instructions, etc. The ad hoc committee will be tasked with devising such a form. OPEN

4. New Business:

a. Major Bateman informed the committee that a significantly larger number of pati questionnaires are being received from the clinics, most with positive input. Both favorable and unfavorable questionnaires are sent to the sections concerned. There wer three patient questionnaires reviewed by the committee. Colonel Zick requested that patient questionnaires be presented for review at the Professional Staff Meetings. They are currently reviewed at the Charge Nurses' meetings. CLOSED

b. An incident was discussed wherein a patient was given his health record by the attending physician, to handcarry from this hospital for use by a civilian physicia in another state. This item will be presented at the Professional Staff Meeting. OPEN

c. Hospital incident reports were reviewed by Major Bateman with no significant problems discussed. CLOSED

d. The interraction of the Quality Assurance and Risk Management Meetings was discussed. Dr. Paull stated that the Air Force's development of a Risk Management Committee somewhat overlaps what the Joint Commission on Accreditation of Hospitals requires from a Quality Assurance meeting. Many civilian facilities do not have risk management programs; however, it is believed that eventually it will be a requirement at most hospitals. Dr. Paull suggested that possibly a facility of our type could combine the risk management and quality assurance programs into one committee with the functions of the quality assurance manager and the risk manager combined. It was Colonel Kaye's belief that it may be too general to incorporate all risk management/ quality assurance items into one meeting. Medical problems should be discussed under quality assurance, and the risk manager would not be the person to help resolve this type problem. A combined risk manager/quality assurance manager could collate data for both functions. The risk manager should attend meetings wherein risk factors are presented, i.e., Infection Control, Safety, Quality Assurance. This will give him an overview of all problems within the facility. Major Bateman will be attending a Risk Management seminar in March at which time formats that have been developed will be presented. This item will be discussed further at the March Risk Management meeting. OPEN

AGENDA
RISK MANAGEMENT COMMITTEE
29 February 1980

1. Status of Mental Health group therapy program for "Administrative burn-out."

2. Results of audit criteria investigations by committee members.

3. Emergency room items from January Risk Management meeting.

4. Status of patient questionnaire availability throughout hospital.

5. Review Incident reports and patient questionnaires.

6. Review Memo for Record on patient records.

7. Interraction of Quality Assurance/Risk Management.

8. Education of personnel -- briefings by Major Bateman at staff meetings, etc.

9. Discuss draft Hospital Regulation on Risk Management.

10. Course on legal aspects of critical care.

Risk Management Committee Meeting

1. The first meeting of the Risk Management Committee was held in the Hospital Conference Room at 1300 on 24 January 1980.

2. The following members were in attendance:

Col Robert M. Paull	SGH	Chairman
Col James T. Shallow	SGH	Member
Col George A. Kaye	SGA	Member
Col Fay D. Parker	SGHN	Member
Maj Val J. Bateman	SGAA	Member
Capt Maston E. Martin, Jr.	JA	Member
1Lt George M. Provost	SGG	Member (Safety Officer)
Capt Charles W. Boone	SGAA	Admin. Resident

3. Colonel Paull reviewed AFR 168-X (draft of the Risk Management Regulation) paragraphs 10-16, with the following discussions:

a. It was the decision of committee members that the committee will consist of seven members as outlined in paragraph 11, AFR 168-X. If additional expertise is required, personnel will be invited as needed. CLOSED

b. The responsibilities of the committee were reviewed by Col Paull. A major concern expressed was how the committee can insure that audit criteria are clinically valid. The primary purpose of an audit is to determine the quality of care of patients. To this end, criteria are compiled for a certain diagnosis, and patients' clinical records reviewed to determine if the care given meets the criteria as drawn up. Dr. Shallow stated that all our audits are done retrospectively. A topic is chosen for one of several reasons -- it is recognized that a sufficient number of patients have a diagnosis or procedure performed, or the staff has recognized a problem which seems to be arising around a diagnosis or procedure. This item was discussed at great length and it was suggested that outside medical personnel be called upon as consultants to review our criteria for clinical validity. These consultants could be from Fitzsimons Army Medical Center, Wilford-Hall Medical Center, or the civilian professionals in Colorado Springs. Some concern with this approach was expressed; specifically, the question was raised as to whether outside consultants would view the criteria in the light of the purpose for which they were developed, i.e., a recent audit was held regarding appendicitis because of an apparent increase in appendiceal perforations. An additional concern was that as audits are multidisciplinary, review of criteria would require evaluation by multiple individuals and this could involve a considerable time delay.
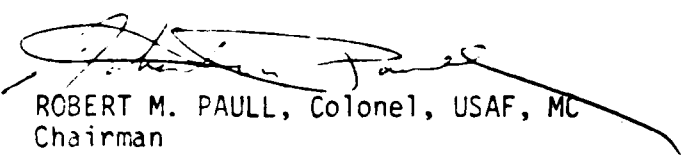
It was agreed that the Risk Management committee should be involved with a review of completed audits to determine whether there is anything within the audits that would comprise a risk management problem. Committee members are tasked with investigating the audit criteria question further for additional discussion at the February Risk Management meeting, in order to resolve how this committee will handle this portion of its responsibility. OPEN

b. Colonel Kaye stated that the Judge Advocate's office will be developing programs for the use of this committee and advising committee members of malpractice claims made against the government, and those claims settled. The Risk Management Committee will

h. Colonel Kaye has recommended to Dr. Fry, Chief, Mental Health, that a program be initiated to assist in the prevention of "administrative burn-out," i.e., those who are responsible for receiving patients sometimes become "hostile" toward them. Dr. Fry suggested a group therapy-type program and stated it could be started the first part of 1980. Dr. Fry will be encouraged to initiate this program inasmuch as a very important facet of medical treatment is the initial reception of the patient. OPEN

i. Colonel Kaye stated there are three basic functions of the Risk Management Committee, i.e., identification and resolution of problems, education and sensitizing of hospital personnel, and optimizing patient relations. CLOSED

j. According to AFR 168-X, the Risk Management Committee is required to meet at least quarterly. Committee members believed that, at inception, it would be to their advantage to hold the meetings monthly. The next meeting was scheduled for 1300, 29 February 1980. The meeting was adjourned at 1405.

ROBERT M. PAULL, Colonel, USAF, MC   V. Ellen Harrison
Chairman   Recorder

                                                  1 Atch
                                                  Draft, AFR 168-X

APPENDIX N

DEPARTMENT OF THE AIR FORCE   HOSPITAL REGULATION 168-1
Headquarters, USAFA Hospital
USAF Academy, Colorado 80840   31 October 1977

Medical Administration

PATIENT QUESTIONNAIRES (PA)

1. **PURPOSE**: This regulation establishes procedures and responsibilities for the distribution and collection of the USAF Academy Hospital Patient Questionnaires, USAFA Form 0-599 A and B.

2. **PRIVACY ACT STATEMENT**: This regulation is affected by the Privacy Act of 1974. Authority: 10 U.S.C. 133, 10 U.S.C. 8012. Principal Purposes: The purpose for requesting this information is to obtain patient's opinions of the various medical services provided by the USAF Academy Hospital. Routine Uses: This information will be used to evaluate care provided to our patients. Information provided will be used to identify problem areas as well as those sections providing superior services. Disclosure is voluntary. There is absolutely no effect on a patient for not completing the questionnaire.

3. **RESPONSIBILITY FOR QUESTIONNAIRE FORMS**: The Registrar will be responsible for maintaining an adequate number of questionnaire forms for the Hospital and Cadet Clinic.

4. **PROCEDURES FOR DISTRIBUTION AND COLLECTION OF QUESTIONNAIRES:**

    a. Distribution to Inpatients - A questionnaire will be given to each patient (unless medically contraindicated) by a member of the nursing staff or ward clerk where assigned prior to patient's discharge.

    b. Collection from Inpatients - A drop box will be located at the information desk at the USAF Academy Hospital. Inpatients will be instructed to place their completed questionnaires in this box when they clear the A&D Office. The ward clerk or nursing staff member will accept receipt of completed questionnaires, and forward these to the Associate Administrator.

    c. Distribution to Outpatients -

    (1) Hospital: The Registrar will be responsible for providing patient questionnaires in the outpatient clinic areas, accessible to all clinic patients who wish to respond.

    (2) Cadet Clinic: The NCOIC of Administrative Services, Cadet Clinic will be responsible for distributing patient questionnaires to outpatients in the Cadet Clinic.

This regulation supersedes HR 168-1, 12 February 1976. (For Summary of Revised, Deleted or Added Material see signature page)
OPR: SGA
DISTRIBUTION: J

APPENDIX O

CLINIC SERVICE QUESTIONNAIRE

Our mission in the Air Force Medical Service is to serve you. Our desire is to serve you well
Often, medical care which is technically the most correct may not fulfill its purpose unless
you believe it is the best. For this reason, your opinion of the manner in which we render
this care is important to us. To help us give you the best medical care possible, we need to
know what you think about our services. Will you please answer the following questions re-
garding this visit to the medical facility? Your comments on both positive as well as nega-
tive answers are solicited. Such comments should be written on the reverse side of this form.
Please drop your questionnaire in the box located in the Waiting Room area.

SECTION I - IDENTIFICATION DATA

1. What is your status?
   - [ ] Male
   - [ ] Female
   - [ ] Active Duty Military
   - [ ] Dependent Active Duty Military
   - [ ] Retired Military
   - [ ] Dependent of Retired/Deceased Military
   - [ ] Other (Please Specify)

SECTION II - CLINIC SERVICE DATA

1. In which clinic were you treated?   [ ] Routine   [ ] Urgent
   - [ ] Primary Care Clinic
   - [ ] Pediatric Clinic
   - [ ] OB-Gyn Clinic
   - [ ] Orthopedic Clinic
   - [ ] Internal Medicine Clinic
   - [ ] Allergy/Immunization Clinic
   - [ ] Urology Clinic
   - [ ] Surgical Clinic
   - [ ] Eye Clinic (Optometry/Ophthalmology)
   - [ ] Ear, Nose and Throat Clinic
   - [ ] Physical Therapy
   - [ ] Dermatology Clinic
   - [ ] Emergency Room

SECTION III- APPOINTMENT SECTION DATA

1. Approximately how long did it take you to get through to the Appointment Desk by
   phone? _____ Minutes.

2. Were you able to get an appointment for the:
   - [ ] Same Day
   - [ ] Next Day
   - [ ] Third Day
   - [ ] Fourth Day
   - [ ] Fifth Day
   - [ ] More than Fifth Day (Please Specify) _____ Days

3. Was prompt and courteous service provided by appointment personnel? [ ] Yes [ ] No

SECTION IV - RECORDS SECTION DATA

1. Were your records available in the clinic when you arrived for your appointment?
   [ ] Yes [ ] No

2. If you picked up your records at the Records Section, did you receive prompt and
   courteous service? [ ] Yes [ ] No [ ] Not Applicable

SECTION V - PATIENT EVALUATION OF CARE RECEIVED

1. Were you seen by the physician/practitioner promptly at the appointed time? [ ] Yes [ ] No

2. If you were not seen by the physician at the appointed time, how long did you wait?
   _____ Minutes.

3. Did you understand the instructions given you by the physician, nurse and/or technician?
   [ ] Yes [ ] No

4. Please rate the services received in the following departments:

DEPARTMENT	EXCELLENT	GOOD	FAIR	POOR
X-Ray				
Laboratory				
Pharmacy				

5. Please rate your reception and treatment rendered by the following personnel:

PERSONNEL	EXCELLENT	GOOD	FAIR	POOR
Physician				
Nurses/PAS				
Technicians				
Volunteers				

6. Please render an overall rating of the services you received.

INPATIENT QUESTIONNAIRE

Our hospital staff wishes to provide you with the best medical care and believes everything possible is being done to make your stay more comfortable and pleasant. You, as a patient, can aid us in improving care even further by removing petty annoyances, and correcting attitudes which detract from our hospital's performance. To assist us in this endeavor, would l you please answer the questions and provide detailed comments on items answered "fair or poor." Omit questions that do not apply. You need not sign your name unless you wish to do so.

SECTION I - IDENTIFICATION DATA

1. What is your status?

☐ Male
☐ Female
☐ Active Duty Military
☐ Dependent Active Duty Military

☐ Retired Military
☐ Dependent of Retired/Deceased Military
☐ Other (Please Specify)

SECTION II - PATIENT LOCATION AREA

1. On what ward were you assigned?

Obstetrics
Nursing Unit 3
Nursing Unit 4

Pediatrics
Intensive Care

SECTION III - INPATIENT CARE DATA

	EXCELLENT	GOOD	FAIR	POOR
1. The physician's interest in you as a patient was				
2. The explanation of your illness and the explanation of treatment rendered was				
3. How well were tests and procedures explained to you?				
4. Please rate the nursing care you received from nurses, medical technicians and aides, with respect to the:				
a. Consideration in providing you with personal care				
b. Interest in you as a person				
c. Promptness in answering the nurse call buzzer				
d. Responsiveness of the staff to your needs				
e. Noise level during the change of shift				
f. Keeping your bedside area neat				

5. Personnel from other departments were also responsible in administering to your health care needs. In this regard, would you also rate the following personnel in providing you prompt and courteous service.

	EXCELLENT	GOOD	FAIR	POOR
a. Laboratory Technicians				
b. X-ray Technicians				
c. Physical Therapists				
d. Volunteers				

SECTION IV - DIETARY DATA

1. Where did you receive your meals? ☐ In your room. ☐ In the dining hall.
2. Were you receiving a ☐ Special diet ☐ Regular diet

	EXCELLENT	GOOD	FAIR	POOR
3. Within the restrictions of diet ordered by our physician, did you enjoy your meals?				
4. Regarding meals:				
a. Serving temperatures of the food - hot foods served hot, cold foods served cold				
b. Menu items tasty and attractively served				
c. Quantity of food served was sufficient for your prescribed diet				
d. The variety of food selections offered on the menu was				

USAFA PREVIOUS EDITION

APPENDIX P

HOSPITAL INCIDENT STATEMENT

HOSPITAL ADDRESS

1.	INCIDENT DATA		
TYPE	**DATE/TIME**		**LOCATION**

2.	PERSONAL DATA

PERSON INVOLVED *(Last, first, middle initial)* — ☐ MALE ☐ FEMALE — **AGE**

☐ MILITARY	**GRADE**	**SSAN**	**ORGANIZATION**	
☐ DEPENDENT	**SPONSOR** *(Name and Grade)*			**RELATION**
☐ CIVILIAN	**ADDRESS**			**PHONE NO.**

3.	STATUS

☐ HOSPITAL PERSONNEL	**DEPARTMENT**		**JOB TITLE**
☐ VISITOR/ OTHER	**REASON FOR BEING IN HOSPITAL**		
☐ INPATIENT ☐ OUTPATIENT	**REGISTER NO.**	**WARD/CLINIC NO.**	**REASON FOR BEING IN HOSPITAL**

A. CONDITION BEFORE INCIDENT

☐ NORMAL ☐ SENILE ☐ SEDATED ☐ OTHER *(Describe)*
☐ DISORIENTED ☐ UNSTEADY

4.	COMPLETE IF PROPERTY/EQUIPMENT INVOLVED

DESCRIBE PROPERTY/EQUIPMENT

5.	COMPLETE IF BED INVOLVED	
HEIGHT OF BED ADJUSTABLE	**BED RAILS PRESENT**	**FOOTSTOOL BY BED**
☐ YES ☐ UP	☐ YES ☐ UP ☐ ORDERED	☐ YES ☐ NO
☐ NO ☐ DOWN	☐ NO ☐ DOWN	

6.	COMPLETE IF MEDICATION INVOLVED *(Medicine Administered)*		
☐ WRONG PATIENT	☐ INCORRECT AMOUNT	☐ FAILURE TO ADMINISTER	☐ FAILURE TO ADMINISTER AS PRESCRIBED OR NORMAL ACCEPTABLE PRACTICE
☐ WRONG MEDICINE	☐ WRONG TIME	☐ FAILURE TO ADMINISTER AT TIME SPECIFIED	☐ OTHER *(Specify)*

7. NARRATIVE OF INCIDENT *(Describe exactly what happened, causes, injuries, property/equipment damages)* *(Continue on reverse)*

AF FORM **765** JUL 73

USAFA, USAF Academy CO 74-0231

APPENDIX Q

DEPARTMENT OF THE AIR FORCE
USAF Academy Hospital
USAF Academy, CO 80840

HR 168-2

Medical Administration

RISK MANAGEMENT IN MEDICAL CARE DELIVERY

This regulation outlines the policy, procedure, and responsibilities for the operation of the risk management program at the USAF Academy Hospital.

1. REFERENCES:

    a. AFR 92-1, Fire Protection Program.
    b. AFR 127-12, Air Force Occupational Safety and Health Program.
    c. AFR 127-101, Ground-Accident Prevention Handbook.
    d. AFR 160-3, Prevention of Electrical Shock Hazards in Hospitals.
    e. AFR 160-12, Professional Policies and Procedures.
    f. AFR 160-24, Standards for Blood Banks and Transfusion Services.
    g. AFR 160-41, Credentials Review of Health Care Providers.
    h. AFR 160-56, The Operating Room Technician.
    i. AFR 160-152, Control of Radiological Health Hazards.
    j. AFR 161-6, Control of Communicable Diseases.
    k. AFR 161-8, Control and Recording Procedures - Occupational Exposure to Ionizing Radiation.
    l. AFR 161-12, USAF Epidemiological Services.
    m. AFR 167-1, Preventative Maintenance Procedures and Serviceability Standards for Medical Equipment.
    n. AFR 167-6, Ambulances and Special Medical Vehicles.
    o. AFM 168-4, Administration of Medical Activities.
    p. AFR 168-12, Standard Policies, Definitions, and Data Presentations Relating to Fixed Medical Treatment Facilities and Patient Accountability.
    q. AFR 168-X, Risk Management in Medical Care Delivery
    r. AFR 169-5, Education and Training for Medical Service Officers.
    s. AFR 169-6, Clinical Investigation and Human Test Subjects in the Medical Service.
    t. HR 11-5, Administrative Officer of the Day and Noncommissioned Officer of the Day.
    u. HR 11-6, Hospital Security/Resource Protection Program.
    v. HR 92-1, Fire Protection Procedures.
    w. HR 123-1, Self-Inspection Program.
    x. HP 123-1, Hospital Self-Inspection Checklist.
    y. HR 127-1, Hospital Safety.
    z. HR 160-1, Medical Officer of the Day.
    aa. HR 160-6, Procedure for Reporting Adverse Drug Reactions.
    ab. HR 160-7, Minor Patient Surgery.
    ac. HR 160-8, Operating Room Services.
    ad. HR 160-9, Management, Security and Destruction of Disposable Needles and Syringes.
    ae. HR 160-10, Primary Care.
    af. HR 160-11, Cardio-Pulmonary Lab Services.
    ag. HR 160-12, Recovery Room Procedures.
    ah. HR 160-24, Code Blue Procedures.

b. Risk Manager. The individual, designated in writing by the Hospital
Commander, responsible for directing and coordinating the hospital's risk
management program.

c. Risk Management Committee. The hospital committee having the responsi-
bility to review risk management matters with vested authority, subject to the
approval of the Hospital Commander, to direct appropriate action.

d. Legal Advisor. An attorney designated by HQ SQ/JA serves as legal
advisor for the hospital's risk management program. He or she will attend
risk management committee meetings, assist in education/training presentations
on medical law topics, and maintain close liaison with the risk manager on
any potential claims arising in the hospital.

4. RESPONSIBILITIES.

a. To achieve the policy expressed in paragraph 1, the risk management
program will involve three basic functions:

(1) Identification and resolution of problems.

(2) Education and sensitizing of hospital personnel.

(3) Optimizing patient relations.

While responsibility for managing these functions lies with the Risk Manager
and Risk Management Committee, the responsibility for supporting the functions
lies with all hospital personnel.

b. The Risk Manager.

(1) The associate administrator, USAF Academy Hospital, is designated
the risk manager. The risk manager will play a vital role in the three basic
functions described above. The Risk Manager is responsible for screening and
coordinating information from various sources which identifies problems or
potential problems in health care delivery. Numerous quality assurance functions,
with specific areas of responsibility, exist and operate effectively within the

c. The Legal Advisor. The Legal Advisor will attend all risk management committee meetings, assist in education/training presentations on medical law topics and maintain close liaison with the Risk Manager on any potential claims arising in the medical facility.

d. The Patient Advocate. The Patient Advocate will:

(1) Ensure the availability of adequate mechanisms for ascertaining patient satisfaction with services rendered by the hospital.

(2) Publicize the patient advocacy program (in conjunction with the hospital Public Affairs Office), ensuring that all personnel utilizing the hospital are aware that this channel of communication is readily accessible.

(3) Attend meetings of the Risk Management Committee.

e. The Assistant Administrator/Patient Affairs will:

(1) Serve as Hospital Public Affairs Officer

(2) Effect a system whereby the Registered Records Administrator, during the normal review of inpatient records on discharged patients, identifies the occurrence of the following:

(a) Sudden unexplained deaths.

(b) Injuries sustained secondary to treatment.

(c) Medication errors.

(d) Patient falls.

(e) Mishaps due to faulty equipment.

(f) Expressions of patient dissatisfaction.

(g) Unexplained requests for records from attorneys.

(h) Repeat admissions for the same diagnosis.

(i) Delays in surgery.

(j) Delay in admission from the Emergency Room.

(k) Patient assaults of hospital staff members.

(l) Repeat surgery for the same condition/complication.

assure that facility monitoring efforts, including medical audits, are

directed toward priority and/or identified problem areas. In this regard,

it will assure that the criteria used in medical audits are clinically valid.

(b) Referral of problems to higher headquarters when the solution

is partially or wholly beyond the scope of the committee.

(c) Review of committee minutes of other committees within the

facility for items involving risk management. In this regard, the committee

will assure that all hospital committees are aware of the risk management

program and the responsibility to communicate appropriate items to the Risk

Manager or Risk Management Committee.

(d) Support of Risk Manager in the education/training of hospital

personnel.

(e) Follow-up. Effective management of the program requires that

the remedial action be monitored to assure the action is appropriate and that

the desired result is being obtained. This may include special reports back to

the committee from other hospital committees or functions.

(f) Annual Reassessment. The committee will analyze the operation

of the program annually to determine if the scope, structure, and priorities

which have been established for the hospital are appropriate.

5. PROCEDURES.

a. Incident Reporting.

(1) Consistent and timely reporting of incidents is essential to

effective risk management. Therefore, the appropriate use of AF Form 765, Hospital

Incident Report, will be regularly demonstrated and reiterated in personnel

training. Incidents may include any happening or result not consistent with

routine hospital operation or the routine care of a patient. While the scope

of what should be reported cannot be specifically defined, it does include

any situations which may lead to a claim.

(3) The Risk Manager will review all completed questionnaires and obtain comments from the appropriate department chief on those warranting comments.

(4) The Risk Manager will retain completed questionnaires in his office for 12 months.

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